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THE JOURNAL
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Sporothrichosis—Report of Case.

RALPH C. HENDERSON, M.D., Erie, Kan.

Read before the Kansas Medical Society at Salina, Kansas, May 2, 3 and 4, 1917.

The first case of sporotrichosis in man was reported by B. R. Schenck in 1898. In May, 1909, William K. Trimble and Frederick W. Shaw reported their very interesting case before this society. Between 1898 and 1910, a period of twelve years, when Richard S. Sutton published his first article on the subject, fifteen cases were reported. At that time Sutton reported his first case. A report of four cases followed this one, and in December, 1910, in his second article in The Journal of the American Medical Association entitled "Sporotrichosis in America," Sutton reported two more cases. In the same publication of November 2, 1912, appeared a most valuable article by William W. Hamburger entitled "Sporotrichosis in Man," with a summary of all cases reported in the United States and a consideration of the clinical varieties and the important factors in the differential diagnosis.

Up until that time fifty-eight cases had been reported. Since then I am able to find reports of but twenty-four, and with the one I am now to report, make in all eighty-three cases reported in the United States since Schenck reported the first one in 1898.

This would lead one to suppose that this disease is comparatively rare, which I hardly believe is true. It seems quite probable that sporotrichosis is a prevalent disease, particularly in the rural and farming districts, and more particularly in the Middle West, and that many chronic ulcerative processes are unrecognized sporotrichosis. It behooves us then to better understand the clinical picture of this condition, so as to make a proper diagnosis, and not treat it surgically, as has frequently been done, causing the patient weeks of unnecessary suffering. The writer pleads guilty to this charge in one case, but never again. In this district we should be particularly interested, because of the eighty-three cases reported sixty-nine were from the Mississippi Valley, and Kansas ranks next to North Dakota in the number of cases: the former with fourteen cases and the latter twenty-two.

Sporotrichosis exists in four clinical varieties as classified by de Beurman: 1—Localized sporotrichosis with sporotrichotic chancre and ascending lymphangitis and local lymphadenitis. 2—Disseminated gummatous sporotrichosis; multiple subcutaneous nodules distributed without systematic arrangement throughout the body; early small, hard, painless, round masses; late small and large soft cold abscesses. No ulceration. 3—Disseminated ulcerative sporotrichosis; multiple polymorphic ulcerations of the nature of tuberculous, syphilitic, ecthymatous, rupial, furuncular lesions or a mixture of these. 4—Extracutaneous sporotrichosis, with localization in mucous membranes, muscles, bones, joints, occular tissues, synovial membranes, kidneys and lungs. The first, or cutaneous, variety is the one generally found in America, there having been reported but four cases other than this, and they were of the extracutaneous form—one of the eye,

one of the kidney, and two of the lungs.

The infection generally follows some slight traumatic lesion of the face or extremities. Superficial ulceration invariably follows the infection. After a few days or weeks, one or more chains of small, hard, and painless nodules develop along the course of the lymphatics draining the part. Later, these soften and break down, and if allowed to go untreated, break through the overlying skin, forming superficial ulcers and fistulæ. These ulcerations are usually very persistent. There is generally no pain, no effect on the general health and no rise of temperature.

The organism responsible for the disease is an aerobic fungus, consisting of a branching septate mycelium from which ovoid bodies, or spores, develop by budding, either from the extremities of lateral or terminal filaments or from the extremities of the threads. It grows well on all ordinary culture media, and the mycelium and spores stain well with the ordinary dyes.

The course of the disease in some of the lower animals differs but little from that in man. The horse, dog, cat, mouse, rat, monkey, and guinea pig are susceptible. K. T. Meyer, who has given this subject a great deal of study, does not think that sporotrichosis is frequently transmitted from these animals to man; that they are more generally passive rather than active carriers, harboring the sporothrix in their mouths and on the skin and hair. The same is also true of birds and fowls. They may carry the organism on their beaks, and thus infect man by their bites. De Beurman has shown that on the bark of trees particularly, and on vegetable matter in general, the sporotricha develop saprophytically.

The following points are helpful in making a differential diagnosis. The occurrance in a rural community. The history of a trauma of the hand, forearm, or leg followed by a slow incubation, insidious onset, and slow infection ascending from the lesion along the course of the lymphatics. The appearance of small, hard, subcutaneous nodules, gradually softening and breaking down, forming superficial ulcers. The long duration of the disease, with little or no pain, no rise of temperature, and general good health. Finally, the cultivation of the organism on artificial media.

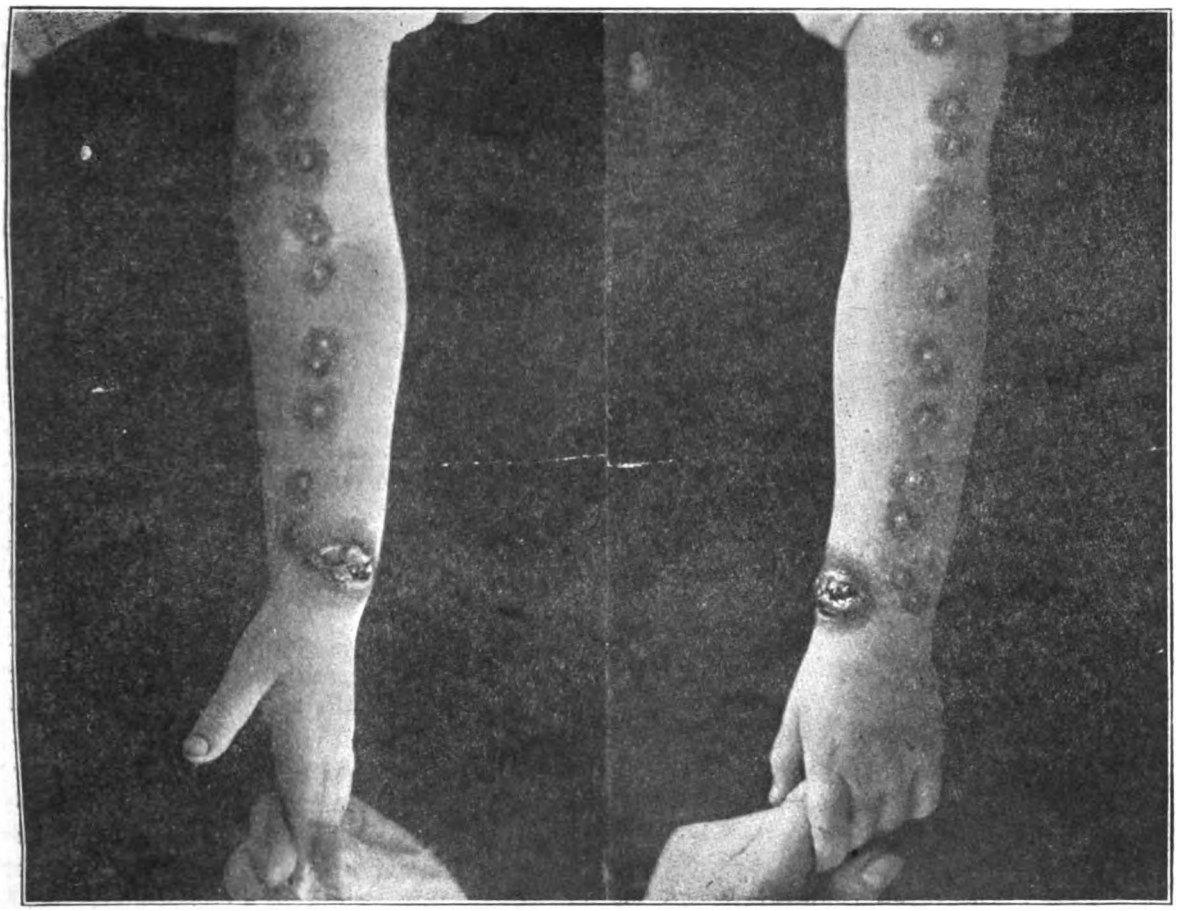
In considering the treatment, there is one thing to remember always: Do not incise the nodules. Apply to them, locally, the tincture of iodine every second or third day. Apply the tincture, also, to the ulcer, and dress with plain gauze. In case the nodules undergo ulceration, treat them the same as the primary lesion. Use no other antiseptics, as they are useless. Give the iodide of potassium, internally, in increasing doses until the tolerance of the patient is reached. If this line of treatment is pursued, no scarring or disfigurement will result.

The following case which has not heretofore been reported is of interest.

Patient—I. T.—Female, age 4, born in Neosho County, Kansas, plump and well nourished. Father, mother, and two sisters living. Cutaneous history of family is negative. History—On June 16, 1916, the family left Sugar City, Colo., traveling overland in a wagon, arriving in Stark, Kansas, on October 20, 1916.

Present Illness.—A short time after their arrival there the child developed a small pimple on the lower extremity of the left forearm about one-half inch above the styloid process and over the external surface of the radius. This began to ulcerate and increase in size. On November 20, 1916, the family moved to Erie, Kansas, and the child was brought to me on December 6, 1916, about four weeks after the pimple first appeared.

The lesion then appeared as a ragged, depressed ulcer, one and one-half inch in length and from one-half to one inch in breadth. The border was raised, edges undermined, and the base was covered with numerous granulations which bled freely when irritated. This ulcer had received no treatment whatever, excepting, on occasional cleansing with warm water by



the mother, and the only protection was that of a clean cloth. In her ignorance of what to do, she did the right thing. No phenol, turpentine, mud poultices, salves, or any of the other numerous domestic remedies had been applied.

The ulcer was clean. No pus or debris whatever. Extending upward from this along the posterior surface of the forearm and arm, on the ulnar side, were twelve nodules, and on the anterior surface were nine nodules, extending up to the axilla; there was also one just above the internal condyle. The axillary and epitrochlear glands were not involved. The nodules were hard, movable, and painless, and about the size of a small cherry. In a few days they began to break down, soften, and turn a purplish color. They were then slightly tender to the touch. They did not ulcerate, neither did I incise them. The patient had no pain nor rise of temperature. She slept well and her appetite was good. She played and romped with the other children as usual, and walked seven blocks to my office every other day during the very cold weather.

A clinical diagnosis of sporotrichosis was made. Bacteriologic Examination. Smears made from the initial lesion, stained with Wright's and Methylene-blue, showed the mycelia and spores, but no pus germs. The lesion being absolutely clean. One of the nodules was aspirated with a sterile syringe and a pure culture of the sporothrix Schenckii obtained. Another one was aspirated and four agar tubes were inoculated. These were incubated at room temperature and, seven days later, pure cultures of the organism had developed on all the slants.

Treatment. — The nodules were not incised. They as well as the initial lesion were painted with the tincture of iodine every other day for three weeks, then every fourth day for the remaining three

weeks. No other local treatment was applied. Potassium iodide was administered three times a day, beginning with 2-grain doses and increasing to 15 grains. On January 17, 1917, the patient was discharged cured, six weeks from the date of the first visit.

Comment.—The origin of this case is uncertain. One of the horses driven from Colorado developed distemper after arriving in Neosho County, but recovered. There were no open sores nor glandular enlargement according to the statement of the father. The other horse was healthy. The children brought a pet rabbit from Colorado, and this, also, appeared to be in a healthy condition. The only explanation of the origin of the infection that seems plausible is that the patient became infected at one of the numerous camping places along the route.

This case, to my mind, is typical of sporotrichosis, in this country, and is attended with several interesting features. First, the age of the patient, she being four years old; there having been but two younger reported, one by Quain, age three years, and the other by Ruediger and Smith, age three and a half years, both females. Second, that no treatment or household remedies had been applied previous to my seeing the case. Third, the clean condition of the initial lesion, no mixed infection. Fourth, smears made from the lesion demonstrated the organism.

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The Educational Function of the Hospital.

MAYME CONKLIN, R.N., Topeka, Kan.

Read before Kansas State Hospital Association, May, 1917.

Writing on the subject of education, Herbert Spencer said: "To prepare us for complete living is the function which education has to discharge." The old theory of education was that it was the acquisition of knowledge; the new theory as promulgated by Spencer, is that it is a training of the mental faculties, so that in addition to knowing about things, we are also taught how to accomplish things.

The first duty of the hospitals is, of course, to provide for the care and treatment of its patients; but it also has a function beyond this, and that is educational. In the broadest sense, hospitals may be said to be educational to physicians, medical students, nurses, patients, employes and to the community. While the majority of hospitals are not so located as to be available for students of medicine, all hospitals to a certain extent are educational to the other classes mentioned.

It is unquestionably true that hospitals are becoming each year more and more important factors in the preservation of the public health. There is a constantly growing appreciation of what the hospital means to those who are ill, of its possibilities for educational work and for investigation and research, which while not interfering with the actual care of the patients (the result being quite the contrary), present possibilities of a greater service to mankind generally. The hospital which welcomes teaching within its walls insures more careful methods, more careful study of the individual case and, generally speaking, better and more thorough treatment for its patients.

In this country we have been surprisingly slow to grasp this fact, considering that the growth of the hospital movement has been so rapid. It is quite probable that the rapidity of hospital development in America has been largely responsible for the lack of appreciation of the larger opportunities. It was only a few years ago that the hospital in this country was considered the place of last resort. Today almost a complete reversal of opinion has taken place and it is now considered the place of first resort for anyone who is seriously ill. With this growing appreciation of the value of the hospital, there has occurred a mushroom-like growth of hospitals, attended with all the evils of too rapid development, namely lack of standards or organization and management, lack of standards as to support, poorly formulated plans, mismanagement and failure to

comprehend the greater possibilities of the movement.

Within the last few years, however, there has come a broader conception of what the hospital stands for and of its greater usefulness. This is largely true because of the educational function of the hospital. I have said that the hospital is educational to practically all who live and work within its walls, and to the community as well. Who can doubt that the employes working day after day in such an atmosphere must learn something of value in the way of helpfulness to others, something finer and broader by way of appreciation of life's problems, of human frailties, and of self-sacrificing service to others? Who can doubt that the patients, many of them at least, learn these same lessons and at the same time learn how to take better care of their own bodies and how not to be a source of danger to others? These are phases of the educational function not often considered, but nevertheless important.

Of the more important phases, let us consider the education of medical students. In the so-called teaching hospitals, thousands of medical students are trained each year, both in theory and practice. They are enabled to interview patients and thereby learn how to elicit the necessary information. They are taught what facts to emphasize and what to ignore, what to retain and what to discard. They learn how to examine a patient in order to bring out the abnormal conditions. They learn from the teacher and by actual experience how to recognize a condition and how to reason from the phenomena presented back to the conditions underlying them. Furthermore, having learned at the bedside to recognize abnormal conditions, they learn also what is the proper therapeutic measure, and how to carry it out, which is quite as important. They are taught not only about a thing, but how to perceive the thing itself. The hospital, then, is the training school for thousands of young men, who go forth each year to give to their fellow man the benefit of that knowledge.

Again, every hospital has its resident staff, numbering all the way from one to a hundred. These young men, already recognized as physicians, continue for one or more years to serve the hospital in order to acquire additional skill in diagnosis, in treatment, in operative technique and in powers of observation and reasoning. Then too, there is the senior staff of physicians and surgeons, who by study of the large groups of patience, by the experience gained in operating upon large numbers of patients, acquire a skill and technique which makes them authorities in their subjects and leaders in their profession.

I am aware that I am telling you nothing new, that in fact I am only repeating in a little different form what has been said over and over again. Nevertheless, it seems to me that it bears repetition, for the true value of the hospital, in the broadest sense, is not yet generally recognized.

There remains one, a most important phase of the educational function of the hospital—I might say the most important phase—namely, the education of the nurse. I wish to dwell at some length on this subject, because of the need of a more accurate perception of its possibilities. The training school for nurses represents one of the most important departments of the hospital, both because of its function in nursing the patients and because of the public demand for trained nurses.

Not many training schools for nurses have been started with such a broad conception of the needs, the aims or the value of such a school, as an educational institution. I have said that the growth of the hospital movement has been remarkable. The growth of the nurse training school movement has been equally rapid, for the two have developed together. To this fact we must attribute many of the difficulties which now attend every effort to standardize these schools and to raise the standard of nursing.

To be more explicit, practically every hospital of any size has its training school

for nurses. In the majority of these instances the hospital has established the school, not with any deep-rooted desire to train nurses for the purpose of serving the public generally, or because of any particular interest in education along this or any other line, but with one idea paramount—to get the nursing work of the hospital done in the simplest and cheapest manner possible. Even a superficial study of the situation will convince one that this is not an exaggeration, and that the majority of boards of trustees, medical boards or ladies' committees, have no conception of the great part which the nurse is playing today in all humanitarian work, nor of the inrceased demand for educated, thoroughly trained nurses for all phases of public health work. They think of her only as the pupil and as the private nurse.

Many of these schools — I am almost tempted to say the majority — have standards of admission too low or too elastic, have courses of instruction too meager and too spasmodic, and subordinate too completely the interests of the school, as a school, to the practical needs of the hospital. The point has been made by Mr. Flexner that hospitals owe a duty to medical education, and we heartily agree with him. I would also make the point that hospitals owe a duty to nursing education, and that this is particularly a function of the hospital.

That the trained physician and surgeon play a very important part in the general scheme of life, none will deny. Does anyone believe that the physician and surgeon could begin to do the splendid work which they are doing today without the trained nurse? Without detracting one whit from the credit due the physician and surgeon, we must admit that medical and surgical technique would hardly be what it is today, had it not been for the development of the trained nurse to supplement his work and to assist him in carrying out the complicated and technical procedures of modern practice. That good nursing is often quite as essential as good medical attention, and that it is often equally responsible for a favorable result, none will deny. Furthermore the better trained a pupil is, the better nurse she will be. A nurse cannot be over-trained any more than a physician can be over-trained.

If the hospital owes a duty to medical education, it also owes a duty to nursing education, for the same reason applies, namely, the need of such education in the interest of humanity. Only a few hospitals are available for teaching medical students, while many hospitals can educate nurses, and every hospital large enough to properly support, and which properly conducts a training school, renders a great public service by so doing.

The trained nurse is now called upon to perform work which was never contemplated in the beginning. Even the broadest conception did not in the early days conceive of a service much wider than that of skilled attendance upon the sick. In the present day, however, she is a therapeutic agent of great value. She is called upon in almost every phase of our civic and social life to organize, to systematize and to teach, as the private nurse, the visiting nurse, the school nurse, the health department nurse, the rural nurse, sanitary inspector, etc.

Prof. C. E. A. Winslow, of the College of the City of New York, writing on the education of the public health nurse, says:

We need expert sanitary engineers to build and operate our public works; we need sanitary physicians to deal with the broader communal aspects of the spread of communicable disease; we need sanitary bacteriologists and chemists and statisticians to furnish the special expert knowledge by which all these activities must be guided. More than all, however, we need large bodies of sanitary educators to bring our knowledge to bear on the individual citizen who alone can make so much of it effective. Some of these missionaries of sanitation will be physicians, but most of them will be nurses. And that is why in my judgment the visiting nurse is the most important figure in the

modern movement for the protection of the public health.

Dr. J. H. Mason Knox, late president of the American Association for the Study and Prevention of Infant Mortality, writes as follows:

In the last analysis, however, all our work hinges upon the better care of individual babies coming under our influence, and it is here that the trained nurse should be given first place, both because of her unique opportunities and because of the good results which she has and does accomplish.

The training school for nurses, as well as the medical school, must have the facilities for practical training and actual experience in order that the education may be well rounded and complete. Hospitals exist to serve the public. In the broadest sense, then, the hospital should develop along all lines which tend to public service, which are related to public health, and which do not interfere with its primary purpose. In no other way can it attain its fullest efficiency. There are many hospitals, as we all know, which are now exercising this function. In fact to a greater or lesser extent they all do. There is, however, a need of standards, else there is danger that the profession of nursing will become filled with quacks; that the public will be led to accept poor service when the best is needed; that worthy young women will be misled into believing that they are to receive a thorough training, when they are offered only an imitation and superficial training, for which they must give from one to three years of hard, faithful, honest service; danger that the vast possibilities for public service by a profession of skilled workers may be lost because of the failure to foster the growth of this profession and to protect it from commercialism and low standards.

What are the standards needed? In the first place, it should be recognized that this movement which started out simply to meet a hospital need has developed into an educational movement, in response to a vastly more important and vastly broader need of the public at large. In order to safeguard this movement, therefore, each state should standardize its training schools for nurses, and registration should be compulsory as with the physician.

In order that their graduates may be eligible for registration, schools should be obliged to adopt a fairly uniform curriculum, and to give training in all necessary subjects. Only those hospitals which have more than a minimum number of beds and which are so-called general hospitals, should be recognized as capable of conducting training schools.

Many arguments are heard against such measures, as, for instance, the difficulty of getting a sufficient number of nurses to carry on the work of the hospital, and the need of cheaper nursing service for people of moderate means. With regard to the first, it has not yet been demonstrated that raising the standard of the profession would not attract more applicants to the schools. If such did not prove to be the case, then the training of nurse assistants, or attendants, would undoubtedly meet the situation.

As for the second argument—the need of cheaper service—the same can be said of physicians, yet we are constantly raising the requirements of medical schools and are now considering the desirability of a fifth, or hospital interne year, before allowing the physician to practice. We would not think of recommending half-trained physicians. Then why consider half-trained nurses? The need of hospitals arises partly because of the inability of poor people to employ doctors. Why not consider the hospital as meeting the need for nursing as well? At any rate, if a substitute is needed, let it be found without interfering with the development of, and without lowering the standards of, the nursing profession.

In closing, I wish to repeat that in my opinion it is high time that the medical profession and the public should recognize the importance of high standards in the education of the nurse.

The effect of merely intellectual train-

ing in what is commonly spoken of as "useful knowledge," is too often to make one selfish, self-centered, and too much absorbed in the mere mechanics of education, to the neglect of the education of the heart. Training in a hospital is not confined solely to the intellectual sphere; there is also a training in duty, in genuine altruism, in devotion to others and in self-sacrifice for the public good. "To prepare us for complete living is the function which education has to discharge." To prepare us for broader usefulness in public service is a function which the hospital has to discharge.

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Acute Infectious Poliomyelitis.

DR. J. A. RADER, Caney, Kan.

Read before Montgomery County Medical Society at Caney, Kansas, September 21, 1917.

Infantile paralysis should be considered a misnomer, because in the recent epidemic of 1916 in the United States, but mostly in New York City, where there were alone 9,000 cases, numerous cases at sixteen and as old as forty-five were found to have the disease. The statistics of the New York Department of Health show that 80 per cent of the cases were under five years of age, but that the rural cases were of an older age on an average than the urban cases. This is accounted for by the fact that a great number of the urban cases are immunized, and that mild, unrecognized cases—child feeling indisposed a few days, then recovering—are not reported.

The susceptibility of children to poliomyelitis is much less than to the other communicable diseases. In an exposure of 12,146 children only 252 contracted the disease, making a susceptibility of a little over 2 per cent, while in measles 96 per cent contract the disease when exposed, 75 per cent contract whooping cough when exposed, 25 per cent contract scarlet fever when exposed, and 20 per cent contract diphtheria. This susceptibility was further shown in the cases of twins in several families where one would take the disease and the other not. This feature of the disease has been borne out in my experience. One neighborhood in Oklahoma, in five different families, where on an average there were five children in each family, only one in each family had the disease, two children had resulting paralysis in different families. It is thought that the limitation of poliomyelitis in urban epidemics almost entirely to children may be due to the fact that adults had developed a certain degree of immunity, through mild and perhaps unrecognized attacks in their early years, while the persons in more sparsely settled areas had been less exposed to the contagion of the disease in their childhood, but had acquired a degree of immunity which would render them able, as adults, to resist the infection when present in epidemic form. The conclusion is, then, there exists a distinct individual predisposition or susceptibility, and that in New York City they do not expect for several years an epidemic of the disease, because a large percentage of the susceptible children have been attacked or have been immunized by exposure to the disease. A future epidemic could be controlled if we had a method of detecting the 2 per cent of susceptible children and could immunize these against the disease with convalescent serum. It is now generally agreed by the best authorities that the infectious agent is transmitted chiefly by contact with patient or carrier, the usual period of incubation is seven days, but a large number only one, two or three days after exposure.

Out of the maze of uncertainties and wild theories in regard to the specific agencies and the modes of transmission of the disease, which will be soon settled, one point is practically settled and agreed upon by the profession in regard to its treatment and management, and that is that the case of poliomyelitis in its incipiency should be taken to a hospital at once, preferably to the orthopedic, where the cases can get the skill of the best specialists and the equipment for treatment of this disease.

There are four stages in the course of the disease: acute, subacute, convalescent

and chronic. At the Seaside Hospital they are arbitrarily divided. The acute stage covers the first four weeks and corresponds to the active inflammatory process in the cord, and lasts until the cells that have been disabled by effusion have recovered. The subacute stage begins at the fifth week and extends to the time when the cells that have been disabled by light hemorrhage have cleared up. This is placed at the end of four months. The convalescent stage begins at the fifth month and extends to the time when the motor cells that have been disabled by deep hemorrhage have recovered. This should be placed at the end of two years. The chronic stage begins at the third year and represents the permanent paralysis of muscles receiving the nerve supply from the motor cells destroyed by toxemia.

What is the treatment? Complete immobilization of the body in the subacute and possibly in the acute stage, in order to bring a condition of motor cell rest. All treatment of weakened or paralyzed muscles, in whatever part of the body they may be, should be based on the law that a stretched muscle will not regain its tone, and methods and appliances used that will keep the muscles in a position of constant relaxation. If impulses are allowed to enter into a diseased cell that has its outlet blocked, it will either destroy it or cause a more serious condition. Many cases that have not had the immobilization of parts have been found to be due to muscle fatigue and not to true paralysis. Then instead of getting the children up as soon as possible, the opposite course should be pursued. In the convalescent stage muscle training or muscle re-education is valuable with massage. Electricity has no place in the treatment of the disease before the chronic stage, and then its benefits are questionable.

My Obstetric System.

N. C. SPEER, M.D., Osawatomie.

Read before the Miami County Medical Society.

This paper will consist of my observations on this important branch of medicine. No department of our work in my estimation requires more diplomacy, experience and caution. By diplomacy I might say generalship, which in turn requires assurance, and this in turn requires experience. I believe the young practitioner faces more peril in obstetrics than in any other line.

I have five rules that I observe when entering the lying-in chamber:

First—I know that the kidneys are normal.

Second—See that the heart of the mother is as it should be.

Third—Observe if any sources of infection such as furuncles are in the field of labor.

Fourth—Investigate if any placenta presents in the cervical canal.

Fifth—Learn if the occiput is anterior.

When I know that these points are settled in the affirmative, a feeling of assurance prevails and encouragement can be given to all concerned. Then generalship can be put in practice and care must be exercised.

The generalship consists in conserving the woman's reserve force without meddlesome intervention by digital manipulations.

The care consists of keeping a clean field and clean hands. These may seem commonplace remarks but it is easy to err on first principles.

The first stage being disposed of as experience best teaches, then comes the second stage. I believe this stage calls for almost surgical anesthesia, more conveniently chloroform. In this way the perineal floor is preserved intact and the patient's remembrance of the whole labor seems to be much mollified. About one dozen good pains under general anesthesia after the head has passed the pelvic ring will dilate the most stubborn perineum without wound. I have lowered my perineal casualties to almost nil.

The third stage.—This stage was a source of much annoyance to me until I enlisted the aid of the patient in the expression of the placenta. My plan is this: When there is an after-pain, or semblance

of one, I suggest to them to bear down sharply and, with a moderate Crede, a few contractions suffice. I make gentle traction on the cord even if it is condemned. Practice teaches me it is practical.

I advise cremation of the placenta, instead of the usual and time-honored custom followed in rural districts. I tie the cord with a portion of a one-inch gauze bandage. This proves secure, sanitary and available.

A suggestion with regard to the care of the cord: The nurse is advised to raise the dressing and observe each day that no dermatitis arised about the umbilicus. This accident has proven a source of septic peritonitis in two cases under my observation.

My lying-in bed is prepared in the usual way, and then covered with an Emdeco paper blanket. This is effectual to gather all detritus, especially if gauze is used to receive the excess fluid. When the labor is over simply gather the paper sheet and its contents and place in a common heating stove or furnace and the clearing up is over, the bed is dry, and no mass of bedding to be carted to the laundry room. I use rubber gloves now in every case.

I cleanse the perineal region as follows: Have the patient herself take a soapsuds sitz bath, followed by a 1:2000 cyanide of mercury solution used as a sitz. When the skin is dry, I apply, after the patient retires, a rather free application of Tinct. Iodine U.S.P., over the whole field. I require a freshly laundered sheet to be placed directly over the patient. When I have the Emdeco sheet under them and a clean muslin sheet over them, I feel we are as secure as possible. I have had a very few shaved. I think it is advisable, however.

I keep my patients on their feet or in a rocking chair as long as practical. They often become intractible from being kept out of bed, so concede early in many cases. After dilation is well advanced, I keep the fingers in the parturient canal. I cannot see my way clear to do otherwise.

I preserve the waters at all hazards. I believe they should never be broken. Literally speaking, never. I don't give patients water to drink in active labor. They will invariably vomit or become nauseated. In dystocia with good dilatation I use pituitrin. In severe nervousness I give chloral in small doses. I give morphine and hyoscine hypodermically in those with immoderately severe pain.

In malpositions, except breech, as soon as dilatation has been established I do a podalic version under surgical anesthesia. I have only in one case needed to apply instruments to the after-coming head. I confess to not be able, to my satisfaction, to make an external diagnosis of presentation or deliver a case without examining through the birth canal.

I believe pituitrin will be our aid in post partum hemorrhage. I believe horse serum should be available for those who have lost blood. I believe fully in fl. ext. ergot dram one following labor. I do not believe in the indiscriminate use of forceps — they are largely used as time-savers to physicians. I have applied them twice in a year.

I believe patients should be turned frequently in bed after the second day to prevent retroflexion. I believe no patient should be catheterized, if possible. I don't care how clean it is done. Cystitis is so common, I understand, even in best ordered maternities. A patient can be easily raised slightly in a common wash bowl to get required results.

Protargol 5 per cent protects the baby's eyes.

My observations lead me to say that I average one case of labor a week, that 97 per cent are occiput anterior, that 2 per cent are breech, one 1 per cent mixed varieties.

My further observataions are: A Kelly pad is unsafe and should be condemned; that my infections are usually in cases where there was a laceration of perineum; that the primary repair of cervical lacerations are not satisfactory; that post partum hemorrhage and eclampsia can occur after you have gone and begun to forget that you have had a case of confinement; that infections can occur in supposedly well

organized cases; that pleurisy, typhoid and influenza can occur; that it is unwise to interfere with a uterus if infection has occurred and to not manipulate an embolic infection such as the leg or breast; that it is very wise to inquire for the cause if the after-pains are excessive; that frontal headache has invariably preceded any other symptom of a convulsion and never occurred except in albuminuria; that the limbs of the child are very easily fractured in breech cases—I have had both femur and humerus fractures, they responded well to treatment; that the perineum of an an infant in breech cases can be torn—I saw such a case that a very unintelligent midwife injured, she had a good many hours the start of me; that the sacrum can be partially dislocated by too forcible instrumental interference and give the patient pain for many months; that the pubic bones will separate and give some trouble in locomotion for some time, but fully recover.

I have once before mentioned the following method, in this society, and it met strong condemnation, but I raise the question again.

Indications.—A patient has had annoying and ineffectual pains for several days, has been seen by a doctor several times, given slight hypnotics, chloral, etc., no cessation of pains, no dilatation, and her term of pregnancy is due, I believe to introduce a Barnes bag is a heroic operation, so I, after surgically cleansing the vagina, applying dilute iodine to every surface, fully pack with moist aseptic gauze to bring about dilatation. In two cases I had the very fullest results. The procedure is not original, the idea was gleaned from a maternity hospital report. I do not advise its wide application unless the obstetrician has a fully developed technic for cleanliness.

I believe that the greatest sins of the obstetrician are haste, carelessness and fear. These leave in their wake undue cervical and perineal lacerations and chronic infections.

Follow the scriptural injunction in handling a case of confinement: "Avoid the very appearance of evil." In other words, don't let anything happen, ever so trivial; don't count time as an element; take time, forget that there is anything else to do, for if anything unfavorable occurs no trouble would be too great or road too long to have it effaced.

I have lost more nerve force in apprehension over an elevation of temperature in some of these cases than the cost to me in physical endurance when labor occurred. I would not be averse to this specialty but I wouldn't want to do anything else, for it. is somewhat similar to transforming a laborer in the ditch to a finished social leader in a drawing room, to transform a busy practitioner who is a chauffeur, mechanician or hostler into an obstetric attendant and make him fit.

My closing statement is this: I believe it is wise to be entirely frank with all concerned if anything goes wrong.

———B———

Some Uses of Eserine.

CHARLES L. SMITH, M.D., Independence.

Read before the Montgomery County Medical Society, October 19, 1917.

Eserine is a myotic. It produces contraction of the sphincter of the iris by stimulating the endings of the third nerve going to the sphincter and paralyzing the sympathetic fibers to the dilator muscle of the iris (Weeks). It reduces the tension of the eye, but how this is brought about has not been definitely determined. It is used in the strength of one grain to the ounce or one-half to one-fourth as strong. It is sometimes used in solution of two to four times as strong. The stronger solutions often throw the ciliary muscle into spasm, causing very severe pain, which usually lasts about thirty minutes. A certain strength of solution may be used for a time and as the eye becomes better the action on the ciliary muscle becomes greater and it becomes necessary to weaken the solution. It is claimed that cocaine used with eserine prevents the irritation and increases the myotic effect, a weaker solution in the form of an oint-

ment will accomplish the same result.

In the treatment of ulcers of the cornea, atropin is often used to prevent the complications of iritis, to relieve the pain due to the congestion of iris and ciliary body; and thus facilitate recovery. In young patients it is quite uniformly good, but in persons past middle life it may increase the tension of the eye to such a degree that it appears as though the circulation of fluids in the cornea were inhibited as an ulcer will remain stationary for days. The use of eserine even in the presence of iritis is often indicated. The use of eserine 1:1000 or stronger for a few days will cause the ulcer to begin healing. When it has progressed sufficiently the eserine can be discontinued and atropin substituted to combat the iritis. If the iritis is mild, atropin is not always necessary, as small adhesions will become free under eserine.

On the seventh of July, 1916, a man 70 years of age, of good health and rugged appearance, came to me with a large ulcer of left cornea. The eye had been sore for ten days and for a week he had used the treatment of his family physician—atropin drops, argyrol and hot applications. He had not been able to sleep much for several nights. The eye was very red, beefy-looking and quite hard. The ulcer appeared about ready to perforate.

He was immediately put on eserine 1:1000 at frequent intervals with argyrol and hot applications. The pain became easier in a short time and he was able to sleep some that night. This treatment was continued for one week when at evening we changed to atropin because of the iritis, and he had a very poor night, so he was put back on the eserine. This treatment was continued two weeks, till the 29th, when he was dismissed practically well. Before dismissing him the iris was tested and found free although he had had small posterior adhesions.

April 26, 1916, a man 58 years of age, of good health but not very rugged looking, came to the office with a marginal ulcer of the left eye. The ulcer was about 1 by 2½ m.m. at right upper margin. He said he splashed some paint into the eye about two weeks before. He had been using home remedies and the pain had become not extremely severe, but so that he could not sleep. The injection was only moderate, but the tension was greater than in the uninjured eye.

After irrigating with boric acid solution the ulcer was touched up with 4 per cent trichloracitic acid, eserine instilled and later argyrol dropped into the eye and a bandage applied. Eserine was instilled several times daily. At the end of a week he was dismissed well.

In contusion of the eye from blunt objects with or without hemorrhage into the anterior chamber, it is commonly well to instill atropin to quiet the iris and relieve pain. In some of these injuries the eye is thrown into a state of glaucoma. This summer I have had to treat two cases of glaucomatous eye following blows on the eye with a blunt object.

A young man, about 23 years of age, was kicked in the left eye by a colt, July 11. Apparently the toe of the hoof just reached the eye, causing a cut of cornea at lower right quadrant and causing more or less contusion to eyeball. This happened Wednesday and up till Friday he could see all right, he said. He then "had a hemorrhage" in the eye, and a second hemorrhage the following Tuesday night. I saw him on Thursday, ten days after the injury. He had been driving in to his local town, eight miles, to have it treated. He had been using, three times daily, a cleansing solution and some colorless drops.

He was brought to the office and pretty promptly fainted away as I attempted to examine the eye. The eye was badly injected, of stony hardness, anterior chamber filled with blood, and lids swollen. He was very reluctant to go to the hospital, but finally consented to go, but would not permit a paracentesis to be performed to remove the blood from the anterior chamber. He was put on eserine 1:500 or 1:1000 every two hours with hot applications and morphine if needed. He had been given morphine twice daily for several days. He

was given a quarter of morphine only at the office. The eserine gave quite a bit of relief so that he slept some each night. The fourth day he consented to have a paracentesis of the anterior chamber. The blood was evacuated, which gave great relief. About three-fourths of the cornea was so stained with blood that nothing definite could be made out except a widely dilated pupil. Still he could see light and some objects. For several days the pupil remained dilated ad maximum and I gave the opinion that there was paralysis of the iris. After four days the pupil began to contract and at ten days after the paracentesis the upper part and sides of pupil that could be seen were about at normal. The lens could be seen in the pupil. After two weeks in the hospital he went to friends in the city and convalesced for two weeks, mostly in bed. The lens could be seen resting slightly on the pupillary margin of iris below. Against the lens below appeared what I took to be detached retina. He still could see objects through the stained cornea. I was told this week, October 17, that the eye gave no trouble and he still could see some.

Case No. 2, of trauma with blood in anterior chamber: September 29 of this year a boy ten years of age while playing with a sling and small stone struck himself on the side of the nose and the right eye. This was in the forenoon. As he made no special complaint, but little was thought of the accident that day. But he did not sleep well at night and complained of some pain, so his father brought him to me early the next morning. The eye was somewhat injected, tender to touch, with marked increase of tension, and the anterior chamber was two-thirds full of blood. He claimed he could not see objects.

After irrigating with boric acid solution, eserine 1:1000 was instilled. Within ten minutes the boy remarked that the eye felt "better." In about thirty minutes the eye appeared less hard, so eserine was instilled again, a bandage put on and the boy sent home with instructions that eserine be instilled again in two hours. I saw him again four hours later when the tension was perceptibly less. The eserine was continued at two-hour intervals during the day and three-hour intervals at night. The treatment was then made at three-hour intervals during the day and four-hour intervals at night for the following two days. It was then changed to four-hour intervals during the day only. At the end of five days the blood had entirely disappeared from the anterior chamber and at the end of a week there was but a slight injection of the eye to be seen. At the end of two weeks there was no apparent difference between the two eyes and he could read chart as well with the injured eye as with the uninjured one.

That many children lose eyes yearly from injuries is a sad fact. A certain percentage of the loss is due to the treatment or lack of treatment at the time of the injury and a certain percentage is lost by the continued use of a treatment that is not giving results. Eserine is a safe drug to use so far as the tension of the eye is concerned, although it may not be a safe drug to use immediately after a hemorrhage. In a doubtful case, such as just indicated, a mild irrigation with an occluding dressing, and keeping the child quiet in a moderately darkened room for twenty-four hours, would be good treatment.

Hemorrhage occurs more frequently in eyes with increased tension than in eyes with low tension. That the reduction of the tension of an eye will facilitate the growth of tissue is certain. That it may tend to iritis in cases is true, and one must therefore be prepared to treat the possible complications.

———B———

The Hygeia Hospital is now located in its new and larger quarters at 4733 Vincennes Ave., Chicago, Ill. Physicians who wish to refer cases of drug addiction and alcoholism to Dr. W. K. McLaughlin, superintendent, for treatment, should make special note of the new location of the Hygeia Hospital, since the new quarters are located in a section of Chicago very far from the old address.

THE JOURNAL
of The
Kansas Medical Society

W. E. McVEY, M.D. - - - - - Editor

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Military Discipline and Medicine

One of the medical officers in one of the training camps was "called down" by a colonel of another regiment when he was seen talking with a group of privates.

The medical department is a very essential part of the army and, while its ultimate purpose is the successful prosecution of this great war campaign, its immediate purposes and those of the strictly military organization are very diverse and their points of view widely separated. The ultimate objective in the training of a military organizaation is the destruction of life, and the more destructive the military machine may be made the more efficient it is for the purpose for which it is intended. In so much as the medical department is able to add to the destructive efficiency, to that extent is it of value, from a strictly military point of view. From this point of view the component elements of the ranks are animated machines which must move with promptness and precision at the officer's word of command, and it is the function of the medical department to keep these machines in perfect running order and to repair all damaged parts as quickly and efficiently as possible. But, from the medical officer's point of view, these are yet men, who have nerves as well as bones and muscles, who have sentiment and perception as well as hearing and eyesight, who may suffer from pain, hunger, thirst and exposure, and whose best service may be hindered by grief, homesickness or disappointment.

Too marked social distinction between the medical officer and the private, too great detachment from the personal welfare of the men, will add nothing to the efficiency of the medical department, but will deprive its officers of important sources of information and will prevent a full appreciation of the personal element in every case of illness or injury.

We have no criticism for military regulations which apply to the strictly military organization, although it is hard to understand how discipline is better maintained by the establishment of arbitrary lines of social distinction, in the National Guard or in the National Army. All men respect the uniform, but the man in the uniform must still earn the respect and confidence of his men. But even the uniforms have become more democratic, with much less distinction between those of the officers and those of the privates than was formerly the case.

The relation of medical officers to the men is very different from that of officers of other departments to the men. Medical officers must sometimes get under the uniform, to the man himself. They will find it extremely difficult to maintain the attitude toward their patients that the line officer prescribes. The relation of the doctor to his patient must be an intimate one, whether he is an officer in the army or in civil life.

There are some officers of the line, high in rank and old in service, who are very democratic and permit a great deal of freedom in their relations with the men. They find no lack of discipline on that account, but are generally regarded as excellent officers. They are big enough to be able to dispense with arbitrary rules for the distinction of officers and men.

Whether the medical officer is big enough to command the respect of the men must be proven in each individual case, but his

duties are not such as to be hampered by free social intercourse with them.

There is nothing in the army regulations to justify such exclusiveness on the part of medical officers, or any other officers, as was required by the colonel in the incident referred to above. It is gratifying to note the attitude of those in supreme command as suggested by the letter of the Secretary of War to the President of the Senate and in which he quotes the following as the only rule or regulation now existing in regard to the relationship between officers and enlisted men:

"Superiors are forbidden to injure those under their authority by tyrannical or capricious conduct or by abusive language. While maintaining discipline and the thorough and prompt performance of military duty, all officers, in dealing with enlisted men, will bear in mind the absolute necessity of so treating them as to preserve their self-respect. Officers will keep in as close touch as possible with the men under their command, will strive to build up such relations of confidence and sympathy as will insure the free approach of their men to them for counsel and assistance. This relationship may be gained and maintained without relaxation of the bonds of discipline and with great benefit to the service as a whole."

Mr. Baker closes his letter with the following observation: "I am still persuaded that in the great army we now have in the field and in training there is a growing realization that it is both possible and useful to be faithful to military discipline and at the same time to the democratic ideals of our country."

It is to be hoped that these rules of segregation will be somewhat relaxed, at least in their application to medical officers, for they must be intolerable to every conscientious physician, especially those who have had some years of practice among the people.

———R———

Camouflage.

Either because they like that sort of thing, or because they are supposed to like it, when it is desired to greatly impress the people with the importance of some proposed movement, it is customary to give them a lot of romance with a few facts when a lot of facts would really answer the purpose much better. Sympathy is frequently the incentive to startling changes of public opinion, but it is worked overtime and it sometimes hides the real merits of a praiseworthy measure. To parade innocence and virtue in dirty thoroughfares in order to create public sympathy may be justified in extreme situations, but seems hardly necessary when the action of an intelligent body of men, such as usually constitute a board of health, is the object to be gained.

Among the items sent out in a publicity campaign conducted by the National Hygienic Society we note the following:

"Today, even, there are few people who know just what prompted the Board of Health to take the step it did.

"A Kansas young woman of irreproachable character returned home from a pleasure tour of travel, recounts the Ladies' Home Journal, to find an ulcer developing on her lip. She went to a doctor who pronounced the ulcer of an unmentionable origin. The girl became inconsolable, and her family, distressed almost to distraction, spared no pains nor expense to ascertain the origin of infection. It was established, beyond reasonable doubt, that the girl's misfortune came from the use of a public drinking cup. The case was brought to the attention of the Kansas Board of Health, with the result that the public drinking cup has been ordered abolished on all railroad trains passing through the state, and from all stations, public schools or public institutions of any kind. It is to be regretted that it required a splendid young woman's misfortune to bring about the action taken, but, at least, she has the satisfaction of knowing that through her misfortune she has doubtless been the means of saving thousands of other innocent victims."

Long before the public drinking cup was officially eliminated in Kansas there were a great many people here, and elsewhere, who found abundant reason for its abolishment in the nauseating filthiness of the thing, but there was also plenty of evidence of its being a disease carrier, if the statements found in numerous text-books at that time are to be so considered.

We have no wish to review the history of the public drinking cup regulations, nor to question the truth of the story related, in most particulars. However, if it is true that the sacrifice of the health and happiness of an innocent young lady was required to prompt the action of the Board of Health in a measure which was so obviously a sanitary necessity, we have misjudged the men who constituted that board. Such a story might have been used in the legislature and would have served an excellent purpose there. Our legislatures are very susceptible to that kind of sentiment.

The point in this story of particular interest to the medical profession is, "It was established, beyond reasonable doubt, that the girl's misfortune came from the use of a public drinking cup." As a matter of scientific interest we would like to know what the evidence was and how the source of infection was positively established. There are many practitioners who have ascribed the specific lesions in their fair patients' mouths to similar sources of infection and have fervently wished for a satisfactory line of evidence to produce.

It is not necessary to prove the guilt of the drinking cup to establish the innocence and virtue of the maiden in the story. It is not even necessary to surmise such a virtuous indiscretion as the osculatory salutation of a sweetheart. Since kissing is such a common practice among the members of the fair sex, both the donor and the recipient of the infection may have been entirely innocent. Physicians have sometimes considered the possible disruption of a family a sufficient justification for misinforming a wife of the nature of secondary specific lesions in her mouth. In other cases the lesions have not seemed to the victim of sufficient importance to require the advice of a physician. Such possibilities are perhaps less common than they have been, but even now must certainly be taken into consideration and regarded as more probable sources of infection than the most public drinking cups.

It would be a considerable task to recall and trace all the kisses a sweet young girl would receive during the time that would elapse between the infection and the appearance of a primary lesion. It would be interesting to know how all the other possible sources of infection were eliminated and the guilt of the dringing cup established.

———B———

Income Tax—A Correction.

Our attention has been called to a statement in the last number of the Journal that "Physicians whose gross annual income exceeds $6,000 are required to pay, in addition to the regular tax and surtax, a special tax of 8 per cent." We are advised that this statement should have been "Physicians whose net income—"

———B———

Every Doctor in the Medical Reserve Corps.

What an ideal situation it would be if every doctor in the United States who is mentally, physically and morally fit, was in this corps.

The time is coming, and in the immediate future, when the medical reserve corps of the army must be immensely augmented, and so as to enable the surgeon general to have at his command for immediate assignment, as conditions demand, a sufficient number of trained medical officers, let us take the above thought seriously.

We all know, from past history, the conserving value of an efficient medical corps, and this means number as well as training.

A statement made by one high in authority in the surgeon general's office that "our fighting forces would be disseminated by sickness and casualties in six months, were it not for an efficient army medical corps," clearly emphasizes the importance of every doctor in the United States, meeting the requirements above referred to, accepting a commission in the Medical Reserve Corps of the United States Army.

The struggle in which we are now engaged, and for which we are preparing to take such a prominent part, depends for its success as much upon the medical pro-

fession as it does upon our combatant forces, and while we do not know that any such intention as herein suggested is in the mind of the surgeon general, it would at least give him the necessary corps of medical officers, upon which to draw, and thus serve the best interests of our country and the best interests of the medical officer serving.

Dr. Weil Dies in Service.

The loss of Major Richard Weil, who died of pneumonia on November 19 at Camp Wheeler, Macon, Ga., will be keenly felt in cancer research work. Dr. Weil was a valued member of the American Society for the Control of Cancer. He gave up his work, before war was declared by the United States, to enlist in the service, and was assigned after his training, as Chief of Staff of the Medical Reserve Corps at Camp Wheeler. Dr. Weil was prominent in the work for cancer research at the General Memorial Hospital and was Assistant Director of the cancer laboratories of Cornell University Medical College in New York.

Supplying 3,617 Hospitals.

When the American Distributing Service became the Medical Supplies Service of the Red Cross there were 3,190 hospitals on its lists, situated all over France, but most numerous in the departments back of the front. A hundred new hospitals are added every month, and at the present time there are 3,617 in 1,356 towns. The work in hospital supplies heretofore done by the American Clearing House and the American Fund for French Wounded will be carried forward through this single service.

Under the Red Cross the funds available have been more than doubled. Heretofore, a hospital was given perhaps half the supplies it asked for, now it is given perhaps three-fourths, the French to supply the remainder. Moreover, the service can give more expensive equipment, such as radiographic installations, sterilizing outfits, and the special instruments needed by surgeons at the central hospitals, much more delicate and costly than those called for in the field service. Two-thirds of the appropriation is consumed in routine supplies secured through the Red Cross purchasing section, and one-third direct in the purchase of special instruments and the like. Everything which can be bought in France is bought here, either through commercial channels or from French workrooms employing refugees or crippled soldiers. A three-story garage is used as the main packing and distributing center, and the physical work is done not by volunteers but by convalescents who live and sleep at the Paris hospitals and are paid for the work they do here in the daytime, so that in this way two good ends are served. During July and August the service shipped material to 2,225 hospitals in 5,563 packages weighing 124,158 kilos. The organization has tripled in size since the Red Cross took hold of it.

Our Honor Roll.

We are again publishing the list of members of the Society now in the army service. We have made such corrections and additions as have been furnished. The list is still incomplete and we will be most grateful for any further information—additional names, corrections in rank or assignments. We are particularly desirous of having the correct addresses of these officers. Few of the county secretaries are able to supply full and definite information and we sincerely hope that any reader of the Journal who is able to supply any information along this line will do so.

Allen County Society—
Lieut. O. L. Garlinghouse, M.R.C. (Iola).
Lieut. H. M. Webb, M.R.C. (Humboldt).
Lieut. J. I. Simpson, M.R.C. (Moran).
Lieut. J. S. Sutcliff, M.R.C. (Iola).

Atchison County Society—
Lieut. W. F. Smith (Atchison), M.R.C., Ft. Riley.
Lieut. S. M. Myers (Potter), M.R.C.
Lieut. T. E. Horner (Atchison), M.R.C.
W. K. Fast (Atchison), applied.
C. W. Robinson (Atchison), applied.

Anderson County Society—
Lieut. T. A. Hood (Garnett), M.R.C., Ft. Riley.
Lieut. A. B. Cullum (Garnett), M.R.C., Ft. Riley.
A. J. Turner (Garnett), applied.
L. D. Mills (Greeley), applied.
D. L. Heidrick (Welda), applied.

C. A. Forsythe (Lone Elm), applied.
W. J. Hatfield (Colony), applied.
J. A. Milligan (Garnett), applied.
D. L. Simmons, applied.

Brown County Society—
Capt. W. C. Palmer (Hiawatha), U. S. Inf., Camp Funston.
Lieut. H. L. Goss (Horton), M.R.C.
Lieut. J. S. Rushton (Morrill), M.R.C.
Lieut. H. J. Harker (Horton).

Barton County Society—No report.

Butler County Society—No report.

Bourbon County Society—
Lieut. J. E. Lardner (Fort Scott), M.R.C., Camp Funston.
Lieut. G. S. Lambeth (Bronson), M.R.C., "Somewhere in France."
Capt. J. F. McGill (Fort Scott), M.R.C., Fort Leavenworth.
Lieut. J. R. Brinkley (Fulton), M.R.C., relieved.

Crawford County Society—No report.

Central Kansas Society—No report.

Cloud County Society—
Lieut. M. L. Belot (Clyde), M.R.C., Camp Funston.
Lieut. F. J. Moffatt (Clyde), M.R.C., School of Roentgenology, Kansas City.
R. J. McLaughlin (Clyde), applied.
Lieut. L. E. Haughey (Concordia), M.R.C., Ft. Riley.
Lieut. Ross E. Weaver (Concordia), M.R.C., Ft. Riley.

Cowley County Society—
Lieut. E. H. Clayton (Winfield), M.R.C.,A.S.S.C., Vancouver Barracks, Washington.
Lieut. Walter P. Guy (Winfield), M.R.C., Camp Funston.
Capt. Chas. Hawk (Winfield), M.R.C., Ambulance Co., Ft. Riley.
Lieut. Jones (Winfield), M.R.C.
Lieut. R. Claude Young (Winfield), M.R.C., San Antonio, Texas.
Capt. Milton K. Hawn (Winfield), M.R.C., Hot Springs, Ark.
N. B. Hall (Geuda), applied.

Chautouqua County Society—No report.

Clay County Society—No report.

Cherokee County Society—
Lieut. H. H. Brookhart (Columbus), M.R.C.

Coffey County Society—
Lieut. D. W. Manson (Burlington), M.R.C., Fort Riley.
Capt. M. L. Stockton (Gridley), M.R.C., Fort Riley
Lieut. C. C. Culver (Burlington), M.R.C.
Major H. T. Salisbury (Burlington), M.C.,U.S.N.G., Camp Doniphan.
Lieut. F. C. Boggs (Waverly), M.C.,U.S.N.G., Field Hospital, Camp Doniphan.
Lieut. S. A. McCool (Neosho Falls), M.R.C., Fort Riley.
H. G. Herring (Leroy), applied.

Doniphan County Society—
Lieut. W. A. Gartner (Troy), M.R.C., Fort Riley.
Asst. Surg. H. R. Boone (Highland), U.S.N.M.F., U.S.S. Brutus.

Dickinson County Society—
Lieut. Chas. A. Dieter (Hope), M.R.C.
Lieut. A. E. Harrison (Herington), M.C.,U.S.N.G.
Lieut. D. O. Jackson (Manchester), M.C.,U.S.N.G., Camp Doniphan.
Lieut. H. W. Wright (Enterprise), M.R.C.
W. S. Moore (Longford), passed for commission.

Decatur-Norton County Society—
Lieut. C. W. Cole (Norton), M.R.C., Camp Beauregard, Alexander, La.
Lieut. F. D. Kennedy (Norton), M.R.C., Ft. Leavenworth.

Douglas County Society—
Lieut. Mark Beach (Clinton), Ft. Riley.
Lieut. E. R. Kieth (Lawrence), relieved.
Capt. H. L. Chambers (Lawrence), Ft. Riley.
Lieut. R. E. Barnes (Lawrence).
Maj. Carl Phillips (Lawrence), Camp Doniphan.

Elk County Society—No report.

Franklin County Society—
Lieut. Geo. W. Davis (Ottawa), M.R.C., 11th U.S. Cav. Remount Station, Camp Pike, Little Rock, Ark.
Asst. Surg. W. T. Brown (Williamsburg), U.S.N.R.F., 617 Common St., New Orleans, La.
Lieut. C. C. Bennett (Rantoul), M.C., 187th U.S. Inf., Camp Doniphan.
Lieut. Alexander Haggart (Ottawa), M.R.C., Fort Riley.
Lieut. D. H. Smith (Richmond), M.R.C.

Geary County Society—
Capt. W. A. Carr (Junction City), M.R.C., Sanitary Dept., Camp Funston.
Major F. W. O'Donnell (Junction City), M.R.C., Depot Brigade 89th Division N. A., Camp Funston.
Capt. L. S. Steadman (Junction City), M.R.C.

Harvey County Society—
Lieut. R. Hertzler (Newton), M.R.C., 23d U. S. Inf., Postmaster, N. Y.
Lieut. H. H. Hudson (Newton), M.R.C., Camp Doniphan.
Capt. J. R. Scott (Newton), M.R.C., Ft. Riley.
Lieut. H. M. Glover (Newton), M.R.C., 1st Kansas Ambulance Co., 110th Sanitary Train, Camp Doniphan.
Lieut. R. H. Hartman (Newton), M.R.C., 1st Kansas Ambulance Co., 110th Sanitary Train, Camp Doniphan.
Lieut. L. T. Smith (Newton), M.R.C., inactive list.

Harper County Society—
Capt. B. F. Hawl (Anthony), M.R.C.
Lieut. Chas. B. Stephens (Waldron), M.R.C.
Lieut. C. E. Pessler (Anthony), relieved.

Jefferson County Society—
Lieut. Frank Shaeffer (McLouth), Ft. Riley.
Lieut. A. L. Weisgerber (Perry), M.R.C., Camp Logan.

Johnson County Society—No report.

Jackson County Society—
Capt. Chas. M. Sevier (Holton), M.C.,U.S.N.G.
Lieut. Joseph Adams (Soldier), M.R.C.
Lieut. T. M. Greenwood (Circleville), M.R.C.
Capt. W. L. Wilmoth (Dennison), M.R.C.
Lieut. C. J. Bliss (Mayetta), M.R.C.
Lieut. J. E. McManus (Havensville), M.R.C.

Jewell County Society—No report.

Kingman County Society—No report.

Leavenworth County Society—
Capt. C. J. McGee (Leavenworth), Co. 11, M.O.T.C., Fort Riley.
Capt. J. H. Langworthy (Leavenworth), M.R.C., Ft. Leavenworth.
Lieut. C. E. Brown (Leavenworth), M.R.C., Fort Leavenworth.
Lieut. F. B. Taylor (Leavenworth), M.R.C., Fort Leavenworth.
Lieut. P. B. Matz (Leavenworth), M.R.C., Fort Sam Houston, Texas.
Lieut. A. R. Adams (Easton), M.R.C.

Lincoln County Society—No report.

Labette County Society—
Lieut. R. M. Bennett (Mound Valley), M.R.C.
Lieut. A. R. Nash (Parsons), M.R.C., Camp Funston.
Capt. P. Christman (Parsons), M.R.C., Camp Funston.
Lieut. J. C. Cornell (Parsons), M.C.,U.S.N.G., Field Hospital No. 2, Fort Sill, Okla.
Lieut. E. A. Lodge (Parsons), M.C.,U.S.A.

Lyon CountySociety—
Lieut. C. C. Harvey (Emporia), St. Louis.

Lieut. G. B. Brickell (Americus), Ft. Riley.
Capt. E. E. Haynes (Madison), Ft. Riley.

Linn County Society—No report.

Marshall County Society—
Lieut. E. L. Wilson (Marysville), M.R.C.
Capt. G. I. Thatcher (Blue Rapids), M.R.C.

McPherson County Society—
Lieut. A. Engberg (McPherson), M.R.C., New Mexico.
Lieut. S. N. Mallisson (Canton), M.R.C.

Miami County Society—
Lieut. F. L. McDaniel (Osawatomie), U.S.N.M.F., U.S.S. Balsh.
Lieut. B. F. Fraser (Osawatomie), U.S.M.C., Army Medical School.

Marion County Society—
Lieut. J. F. Coffman (Marion), M.C.U.S.N.G., Camp Doniphan.
Capt. E. B. Johnson (Peabody), M.R.C., Ft. Ben Harrison.
Lieut. H. Brunig (Hillsboro), M.R.C., Camp Funston.
Lieut. L. S. Wagar (Florence), M.R.C., Camp Funston.
Lieut. Clyde Appleby (Peabody), M.R.C., relieved.
Lieut. James Welsh (Herington), M.R.C., Base Hospital, Ft. Riley.

Mitchell County Society—
Lieut. K. P. Mason (Cawker City), M.R.C., Co. 13, Camp Funston.

Montgomery County Society—
Lieut. S. A. Alford (Independence), M.C.,U.S.N.G., Fort Riley.
Lieut. W. G. Norman (Cherryvale), M.R.C., Fort Riley.
Lieut. I. B. Chadwick (Tyro), M.R.C., Fort Riley.
Lieut. Thos. Matlock (Coffeyville), M.R.C.. Chicago, Ill.

Morris County Society—No report.

Nemaha County Society—
Capt. F. F. Carter (Seneca), inactive list.
Lieut. C. E. Toll (Seneca).
Lieut. W. H. Heuschele (Corning).
Lieut. J. C. Maxson (Corning).
Lieut. P. V. Annadown (Centralia).
Lieut. W. G. Bouse (Centralia).
Lieut. S. M. Hibbard (Sabetha).

Neosho County Society—No report.

Osage County Society—No report.

Osborne County Society—
Lieut. E. A. Drake (Natoma), M.R.C.

Pawnee County Society—No report.

Pratt County Society—
Lieut. J. R. Campbell (Coats), M.R.C.
Capt. H. Atkins (Pratt), M.R.C., Fort Riley.
C. E. Martin (Cullison), applied.

Republic County Society—
Lieut. C. V. Haggman (Scandia), M.R.C., Ft. Riley.
J. W. West (Narka), applied.

Rice County Society—
Lieut. Marion Truehart (Sterling), Douglass, N. M.

Reno County Society—
Lieut. L. A. Clary (Hutchinson), Hawaii.
Capt. H. L. Scales (Hutchinson), Ft. Riley.
Lieut. W. L. Mundell (Hutchinson), Camp Funston.
Lieut. N. A. Seehorn (Hutchinson), Camp Pike.
Maj. C. S. Evans (Hutchinson), Camp Doniphan.
Lieut. L. J. Beyer (Hutchinson), inactive list.
Lieut. E. C. Taylor (Pretty Prairie).
Lieut. R. W. Springer (Pretty Prairie).
Lieut. W. H. Kirkpatrick (Haven).
Lieut. W. C. Bundurant (Partridge).
Lieut. James Ungles (Langdon).
G. A. Blasdel (Hutchinson), applied.
G. R. Gage (Hutchinson), applied.

Riley County Society—
Lieut. R. R. Cave (Manhattan), M.C.U.S., "Somewhere in France."

Stafford County Society—
Lieut. C. S. Adams (St. John), M.R.C., Camp Funston.
Capt. J. C. Butler (Stafford), M.R.C., Camp Funston.
Lieut. O. Liston (Hudson), M.R.C., Camp Funston.
Lieut. J. A. H. Webb (Stafford), M.R.C., Camp Funston.

Sedgwick County Society—
Lieut. W. I. Mitchell (Wichita), M.R.C., Ft. Riley.
Lieut. G. K. Purvis (Wichita), M.R.C., Ft. Riley.
Lieut. W. A. Phares (Wichita), M.R.C., Ft. Riley.
Lieut. W. R. Greening (Wichita), M.R.C., Ft. Riley.
Capt. L. M. Metassarin (Wichita), M.R.C., Ft. Riley.
Lieut. R. W. Hissem (Wichita), M.R.C., Ft. Riley.
Lieut. W. T. Doherty (Wichita), M.R.C., Ft. Riley.
Lieut. R. O. Logsdon (Wichita), M.R.C., Ft. Oglethorpe.
Lieut. R. A. Dart (Wichita), M.C., U.S.A.

Sumner County Society—
Capt. J. S. Rudolph (Belle Plaine), Ft. Oglethorpe.
Lieut. D. E. Kessicker (Caldwell), Ft. Riley.
Lieut. J. C. McKinnon (Caldwell), Ft. Riley.
Lieut. Clyde M. Zink (Wellington), Amb. Corps No. 2, Camp Taylor.

Smith County Society—
Lieut. V. E. Watts (Smith Center), M.R.C. (commission received).

Southwest Kansas Society—
Lieut. R. T. Nichols (Liberal), M.R.C., Ft. Riley.
Lieut. A. L. Knisely (Liberal), M.R.C., Camp Bowie, Fort Worth, Texas.
Lieut. B. H. Day (Hugoton), M.R.C., Fort Riley.
Lieut. Jas. Donnell (Kinsley), M.R.C., relieved.

Saline County Society—
Major J. D. Riddell (Salina), M.R.C., Ft. Riley.
Lieut. C. M. Fitzpatrick (Salina), M.R.C., Dept. of Roentgenology, Fort Des Moines, Iowa.
Lieut. J. W. Neptune (Salina), M.R.C.
Capt. A. L. Cludas (Minneapolis), M.R.C., Ft. Riley.

Others from Eighth District—
Lieut. F. E. Harvey (Minneapolis), M.R.C., Ft. Riley.
Lieut. G. M. Anderson (Lincoln), M.R.C., Ft. Riley.
Lieut. Malcolm Newlon (Lincoln), M.R.C., Ft. Riley.
F. S. Hawks (Russell).
J. M. Downs (Ellsworth).

Shawnee County Society—
Major S. A. Hammel (Topeka), M.C.,U.S.N.G., Field Hospital, Ft. Sill.
Capt. C. H. Lerrigo (Topeka), M.R.C., Ambulance Co., Camp Pike.
Capt. S. A. Millard (Topeka), M.R.C., Camp Mills.
Capt. A. K. Owen (Topeka), M.R.C., Ft. Riley.
Lieut. C. C. Lull (Topeka), M.C., 130th F.A.,U.S.N. G., Camp Doniphan.
Lieut. M. K. Lindsay (Topeka), M.C.,U.S.A., Camp Funston.
Lieut. H. K. Rogers (Topeka), M.C., Field Hosp., U.S.N.G., Fort Sill.
Lieut. J. A. Crabb (Topeka), M.R.C., Ambulance Co. 44, Camp Pike.
Lieut. A. M. Dawson (Topeka), M.R.C., Ambulance Co. 44, Camp Pike.
Lieut. J. D. Cook (Topeka), M.R.C., in training at St. Louis.
Lieut. F. J. Ernst (Topeka), M.R.C., Ft. Riley.
Lieut. C. M. Hensley (Topeka), M.R.C., Ft. Riley.
Lieut. J. G. Stewart (Topeka), M.R.C., Ft. Sam Houston.
Lieut. E. G. Brown (Topeka), M.R.C., 1st Colorado Inf., Camp Kearny, Cal.
Lieut. L. C. Bishop (Topeka), M.R.C., special duty as alienist.
Lieut. G. E. Hesner (Topeka), M.R.C., special duty as alienist.
Lieut. F. L. Loveland (Topeka), M.R.C., special duty, Hattiesburg, Miss.

Lieut. L. M. Tomlinson (Harveyville), M.R.C., Ft. Riley.
Lieut. A. L. Weisgerber (Perry), M.R.C., Ft. Riley.
Lieut. G. V. Allen (Topeka), M.R.C., inactive list.
Lieut. W. K. Hobart (Topeka), M.R.C., Ft. Riley.
Lieut. O. L. Erickson (Topeka), M.R.C., Ft. Riley.

Tri-County Society—
Lieut. C. M. Miller (Oakley), M.R.C.
Lieut. G. Winslow (Grainfield), M.R.C.
Lieut. W. J. Lewis (Colby), M.R.C.

Washington County Society—
Major H. D. Smith (Washington), M.C.,U.S.N.G., Fort Sill.
Lieut. G. A. Tooley (Washington), M.R.C., Scofield Barracks, Hawaii.
Lieut. H. B. Hawthorne (Palmer), M.R.C., Ft. Riley.
Lieut. M. H. Horn (Morrowville), M.R.C.

Wyandotte County Society—
Lieut. Geo. M. Gray (Kansas City), M.R.C., Advisor to Governor.
Lieut. L. D. Mabie (Kansas City), M.R.C., inactive list.
Lieut. G. H. L. Hamilton (Kansas City).
Capt. C. C. Nesselrode (Kansas City), M.R.C., inactive list.
Lieut. G. H. McGonigal (Kansas City), M.R.C.
Lieut. W. O. Querring (Kansas City), M.R.C., inactive list.
Capt. J. S. Milne (Kansas City), M.R.C.
Lieut. Thomas Richmond (Kansas City), M.R.C., inactive list.
Pasquale Romeo (Kansas City), Italian army.
Capt. L. B. Spake (Kansas City), M.R.C.
Lieut. R. L. Speck (Kansas City), M.R.C.
Lieut. E. A. Sharp (Kansas City), M.R.C.
Lieut. R. W. Layton (Kansas City), M.R.C.
Lieut. H. W. King (Kansas City), M.R.C.
Fred Candler (Kansas City), applied.
J. F. Hassig (Kansas City), applied.
J. W. May (Kansas City), applied.
Lieut. C. E. Mangun (Kansas City), M.R.C., relieved.

SOCIETY NOTES.

DECATUR-NORTON COUNTY SOCIETY.

The Decatur-Norton County Medical Society held its regular meeting at Norton on Friday, December 21. The following program had been prepared:

President's address, R. M. Tinney.
Broncho Pneumonia, H. M. Norrish.
Diseases of the Hip Joint, W. C. Lathrop.
Appendicitis, C. W. Ward.
Round table.
Election of officers.

SUMNER COUNTY SOCIETY.

The Sumner County Medical Society met in special session at the Commercial Club rooms, Wellington, Kansas, December 6, 1917, 8 P.M. Officers for the year 1918 were elected as follows:

President, Dr. W. E. Bartlette, Belle Plaine; vice president, Dr. W. M. Martin, Wellington; secretary and treasurer, Dr. J. C. Caldwell, Wellington; censor, Dr. F. S. Netherton, Wellington; delegate, Dr. W. H. Neel, Wellington; alternate delegate, Dr. E. A. Evans, Conway Springs.

After the business hour the society listened to a very interesting lecture on "Internal Secretions" by Dr. W. W. Duke, Kansas City, Mo. There was a good attendance. W. H. NEEL, Secretary.

SALINE COUNTY SOCIETY.

The Saline County Medical Society held its annual meeting in Salina on December 13. Dr. A. L. Skoog of Kansas City was present and gave a lecture on "Brain Tumors," which was very interesting and instructive.

After the regular program the annual election of officers was held and the following were elected for the ensuing year: President, J. K. Harvey, Salina; vice president, C. M. Jenney, Salina; secretary W. E. Mowrey, Salina; treasurer, A. G. Anderson, Salina; delegate, J. A. Simpson, Salina; alternate, E. R. Simpson, Gypsum; censor, O. R. Brittain, Salina.

E. G. PADFIELD, Secretary.

BOOKS.

International Clinics.

Volume IV of the Twenty-Seventh Series. A quarterly of illustrated clinical lectures and especially prepared original articles by leading members of the medical profession throughout the world. Edited by H. R. M. Landis, M.D., Philadelphia, with the collaboration of Charles H. Mayo, M.D. Published by J. B. Lippincott Company, Philadelphia and London. Price, $2.00.

This volume of the International Clinics, like its predecessors, contains many very interesting and instructive papers. Albee has a clinic on military bone surgery that is instructive and timely. One of the papers that a great many physicians will be interested in is on the subject of "Blood Pressure in Pregnancy," by Litzenberg. Tucker presents a study of fifteen cases of brain tumor of obscure localization. These are only a few of the very many subjects of interest that are discussed in this volume.

Diseases of the Skin.

Their Pathology and Treatment.—By Milton B. Hartman, A.M., M.D., LL.D., Professor of Dermatology in the University of Pennsylvania. Seven hundred and sixty-seven pages, with 51 colored plates and 242 cuts in the text. Philadelphia and London: J. B. Lippincott Company. Price, $7.00.

This is an entirely new work and one which promises, to be well received. Nothing has been spared in the way of material and workmanship and the author has provided a large number of very excellent illustrations which in treatises on diseases of the skin are of quite as much importance as the text.

The author has attempted to present his subject in harmony with the viewpoint of the general practitioner which is considerable of an undertaking.

The various diseases of the skin are discussed under the following classification heads: Inflammations, Hemorrhages, Hypertrophies, Atrophies, Anomalies of Pigmentation, New Growths, Neuroses, Diseases of the Appendages.

To the subjects of Etiology and Pathology the author has given very thorough attention since in his opinion these are very important to the proper understanding and management of the various lesions. In the treatment he has given the various methods that have been recommended and has been particularly attentive to details in the application of local remedies.

History of Medicine.

Second Edition Revised and Enlarged. Suggestions for study and bibliographic data, by Fielding H. Garrison, A.B., M.D., Principal Assisting Librarian, Surgeon General's Office, Washington, D. C. Octavo of 905 pages with many portraits. W. B. Saunders Company, Philadelphia and London, 1917. Cloth, $6.50 net; half morocco, $8.00 net.

A complete history of medicine, were it possible to uncover and accumulate the manuscript literature of its earlier days, would require several volumes. It is hardly possible to estimate the amount of labor the accomplishment of such a purpose would demand, but a review of this work by Garrison will give some idea of it.

He has given us a very comprehensive view of the progress of medicine and a very interesting compilation of such historical records as are available. In the second edition the work has been improved and enlarged.

A Manual of Anatomy.

By Henry E. Radasch, M.Sc., M.D., Assistant Professor of Histology and Embryology in the Jefferson Medical College, Philadelphia. Octavo of 489 pages with 329 illustrations. Philadelphia and London: W. B. Saunders Company. 1917. Cloth, $3.50 net.

By using much smaller plates and by condensing the descriptive matter somewhat Radasch has been able to put quite a complete work on anatomy into a book of less than 500 pages. Some variation in the arrangement of the text and some change in the nomenclature will be observed.

The Practical Medicine Series.

Under the general editorial charge of Charles L. Mix, A.M., M.D., Professor of Physical Diagnosis in the Northwestern Medical School. Price of this series, $10. The Year Book Publishers, 327 So. LaSalle St., Chicago.

Volume IV—Gynecology: Edited by Emilius C. Dudley, A.M., M.D., Instructor in Gynecology, Northwestern University Medical School; Adjunct Gynecologist, Wesley Hospital, Chicago.

Volume V—Pediatrics: Edited by Isaac A. Abt, M.D., Professor of Piadiatrics, Northwestern University Medical School, Attending Physician Michael Reese Hospital; with the collaboration of A. Levinson, M.D., Associate Pediatrician Michael Reese Hospital. Orthopedic Surgery, edited by John Ridlon, A.M., M.D., Professor of Orthopedic Surgery, Northwestern University Medical School; with the collaboration of Charles A. Parker, M.D.

Volume VI—General Medicine: Edited by Frank Billings, A.B., M.D., Head of the Medical Department and Dean of the Faculty of Rush Medical College, Chicago; assisted by Burrell O. Ralston, A.B., M.D., Resident Pathologist, Presbyterian Hospital.

These are volumes of a series of ten issued at about monthly intervals, and covering the entire field of medicine and surgery. Each volume being complete on the subject of which it treats for the year prior to publication.

Price—Volumes IV and V, $1.35; Volume VI, $1.50.

One of the best opportunities of conserving ammonia is made available by the substitution of natural ice for the manufactured product. This substitution is being provided for throughout the country, and it is expected that a very large percentage of the ice used next summer will be ice that the Food Administration is encouraging people to harvest now from rivers and ponds wherever possible.

MISCELLANEOUS

New and Nonofficial Remedies.

Borcherdt's Malt Sugar.—A mixture containing approximately maltose, 87.40 per cent; dextrin, 4.35 per cent; protein, 4.40 per cent; ash, 1.90 per cent, and moisture, 1.95 per cent. It may be used when maltose is indicated in the feeding of infants, particularly in the treatment of constipation. The Borcherdt Malt Extract Co., Chicago. (Jour. A.M.A., Dec. 1, 1917, p. 1875.)

Tyramine-Roche.—A brand of tyramine hydrochloride complying with the standards of New and Nonofficial Remedies. The Hoffman-LaRoche Chemical Works, New York. (Jour. A.M.A., Dec. 1, 1917, p. 1875.)

Atophan. — A proprietary brand of phenylcinchoninic acid complying with the standards of the U.S.P., but melting between 208 and 212 C. For a description of the actions, uses and dosage, see New and Nonofficial Remedies under Phenylcinchoninic Acid and Phenylconchoninic Acid Derivatives. Atophan is sold in the form of pure atophan and as atophan tablets 0.5 Gm. Schering & Glatz, New York. (Jour. A.M.A., Dec. 8, 1917, p. 1971.)

Arsphenamine. — The Federal Trade Commission having adopted the name "arsphenamine" as the term to apply to 3-diamino-4-dihydroxy-1-arsenobenzene, first introduced as salvarsan, the Council on Pharmacy and Chemistry voted to adopt this abbreviated name in place of arsenphenolamine hydrochloride now in New and Nonofficial Remedies.

Arsenobenzol (Dermatological Research Laboratories.)—A brand of arsphenamine. It has essentially the same actions, uses and dosage as salvarsan. It is supplied in ampules containing, respectively, 0.4 Gm. and 0.6 Gm. Manufactured and sold by the Dermatological Research Laboratories, Philadelphia Polyclinic, Philadelphia, Pa.

Salvarsan.—A brand of arsphenamine. Supplied in 0.6 Gm. ampules. Manufactured and sold by Farbwerke-Hoechst Co., New York.

Chloramine-T.—Sodium paratoluenesulphochloramide. It has the actions, uses, dosage and physical and chemical properties given in New and Nonofficial Remedies, 1917, for chlorazene.

Chloramine-T (Calco). — A brand of chloramine-T. Manufactured by the Calco Chemical Co., Bound Brook, N. J.

Novocaine.—The monohydrochloride of paraaminobenzoyldiethylamino-ethanol. Actions, uses and dosage, see New and Nonofficial Remedies, 1917, p. 31. Manufactured by Farbwerke-Hoechst Co., New York. (Jour. A.M.A., Dec. 22, 1917, p. 2115.)

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Patent Medicine Labels Must Speak Truly.

Ten years ago there was no ailment to which human flesh is heir that some maker of patent medicines did not claim to be able to cure with such ease that it seemed almost the height of foolishness not to part with the price for his nostrums.

Today, because of the operation of the Federal Food and Drugs Act, the extravagant promises of cure that characterized the labeling of the patent medicines of ten years ago have practically disappeared from the preparations that enter interstate commerce. They may, however, still be found in newspaper and other advertisements that are not subject to the act. The "pure food law," as it is known, is concerned only with the package as it is shipped in interstate commerce. If one questions the truth of a newspaper advertisement of a patent medicine, let him read the label on the carton or bottle at the corner drug store. The latter will come nearer telling the truth about the medicine.

Misbrandings, in regard to healing value of hundreds of alleged cancer cures, so-called "cures" for coughs, colds, consumption, kidney diseases, epilepsy, St. Vitus dance, and the like, have been corrected. This is told in the annual report of the Bureau of Chemistry, United States Department of Agriculture, which reviews the operation of the Food and Drugs Act

in the safeguarding of the health of the American people.

The law requires the labels of patent medicines to declare the presence of any habit-forming drug, such as opium, cocaine, or alcohol, thus preventing the innocent development of the drug habit. This provision of the law is particularly valuable in warning mothers against the use of so-called infant soothing syrups containing opium.

When the act went into effect, drug addiction was so prevalent that frauds in the treatment of the victims were frequent and in most instances the remedy advertised so forcefully by the labels contained the very drug from which escape was desired.

In 1907 the Bureau of Chemistry found that thirty soft drinks contained small amounts of cocaine. Practically all of these were suppressed. The Food and Drugs Act is regarded as having been an important factor in bringing about passage of the Harrison Anti-Narcotic law, which more effectively controls habit-forming narcotics.

Much has been done, the report says, to control the indiscriminate use of so-called headache remedies containing dangerous, depressing drugs, and of dangerous cosmetics making claim to healing value; and in raising the quality of the supply of crude drugs through the examination of imports. As a result of co-operative work with the Post Office Department, a number of fraud orders were issued by that department preventing the use of the mails in promoting the sale of fraudulent medicines.

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Neutral Sodium Soap.

For some time Dr. Alexis Carrel has been using, in the War Demonstration Hospital of the Rockefeller Institute, for the cleansing of wounds a liquid sodium soap—a neutral sodium oleate. This has been employed with most satisfactory results.

This soap is used to scrub out an infected wound. A little of it is applied to a pledget of cotton, held with a dressing forceps, and the wound scrubbed with it, more soap being applied to the cotton from time to time until there is a good lather. The wound is scrubbed in this way from the center to the periphery, the soap finally being washed away with water, after which the indicated antiseptic is applied, as, for instance, Chlorazene Surgical Cream.

Neutral Sodium Soap, prepared to meet Doctor Carrel's indications, has been placed on the market by the Abbott Laboratories, Chicago, and is now offered to the medical profession.

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The American Review of Tuberculosis is published by the National Association for the Study and Prevention of Tuberculosis, 105 E. Twenty-second St., New York City.

The purpose of the Review is to give the best information available on tuberculosis from both American and foreign sources and on the clinical, pathological and sociological phases of the disease.

It is the only strictly medical journal on tuberculosis published on the American continent. Its editorial staff consists of the following members: Dr. Edward R. Baldwin, Saranac Lake, editor in chief; Dr. Lawrason Brown, Saranac Lake; Dr. H. R. M. Landis, Philadelphia; Dr. Paul Lewis, Philadelphia; Dr. M. J. Rosenau, Boston; Dr. Henry Sewall, Denver; Dr. B. S. Veeder, St. Louis. Dr. Allen K. Krause of Baltimore is managing editor.

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Chloretone: Hypnotic and Sedative.

Chloretone produces natural sleep. It is indicated in many conditions, such as acute mania, puerperal mania, periodical mania, senile dementia, agitated melancholia, motor excitement of general paresis, insomnia due to pain, as in tabes dorsalis, cancer, and trigeminal neuralgia; also insomnia due to mental overstrain or worry.

Chloretone is a valuable sedative in such conditions as alcoholism, cholera and colic; also in epilepsy, chorea, pertussis, tetanus and other spasmodic affections. It allays the nausea of pregnancy, gastric

ulcer and seasickness. In insomnia it is often effective when other drugs have failed.

Chloretone acts upon the central nervous system, but therapeutic doses have little or no effect upon the heart and respiratory center. The hypnotic dose for an adult is from ten to fifteen grains. Good results have been had with doses as small as seven and one-half grains. Sleep usually follows in half an hour to one hour. One large dose the second night rather than two or more smaller doses would seem to be better practice. Its administration is not attended with digestive disturbances.

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Ten Years of the Food and Drugs Act.

Ten years of enforcement of the Food and Drugs Act of June 30, 1906, are reviewed in the current annual report of the Bureau of Chemistry, United States Department of Agriculture, which says that the Act's chief contributions to the safety of the people's health have been its corrective effect upon the drug and patent medicine industry, its control of trade in unclean milk, polluted, decomposed or filthy foods, and protection of foodstuffs from contamination with poisons likely to be met in manufacture.

The general effect of the Food and Drugs Act may best be estimated, says the report, by considering its effect upon food and drug control by the states; upon development of the food and drug industries and by the principal abuses that have been corrected. But to illustrate the scope of the work through figures and facts the report points out that more than 6,000 prosecutions have been terminated in the courts in the first decade of the Act; that manufacturers have been cited at hearings more than 40,000 times, that many thousands of factory inspections have been made, and that more than 750,000 shipments of domestic or imported food and drugs have been examined.

Special attention has been given to shipments of polluted or spoiled food. Milk shipped in interstate commerce and imported from Canada has been improved in cleanliness, purity, and the condition of sanitation under which produced. The canning of decomposed navy beans has been largely suppressed. Interstate shipment of oysters from polluted waters has practically ceased. Because of co-operation with state and municipal officials in controlling the shipment of bad eggs, it is reported that the quality of the eggs reaching the large cities is much improved. Other products in whose handling and sale improvement has been noted include mineral water, tomato products, fruit, vinegar and gelatin.

One consequence of the-enactment of the Food and Drugs Act was to encourage similar legislation in many of the states the purpose of which is to control local traffic in food and drugs which, since no interstate commerce is involved, are not subject to the federal law. For example, in 1906 many states had no feeding stuffs laws. A state could not prosecute a manufacturer unless he were a citizen of that state. The federal law supplements the state law in this respect and now most of the states have similar laws.

In the beginning the confusion and apparent conflict between local and federal laws and administration of laws not only made it difficult for the two sets of officials to co-operate, but often made it necessary for manufacturers to make special preparations for shipment to certain states at extra cost, the extra cost being passed on to the ultimate consumer. This evil has been remedied to a considerable extent by the organization of two agencies which in a large measure have removed some of the difficulties arising from the conflict of federal and state jurisdiction. These agencies are (1) the Joint Committee on Definitions and Standards and (2) the Office of Co-operative State and Federal Food and Drug Control.

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Deaths of Physicians in 1917.

During 1917, the deaths of 2,300 physicians in the United States and Canada were noted in the Journal of the American

Medical Association. On an estimate of 160,000 physicians, this is equivalent to an annual death rate of 14.37 per thousand. For the fifteen previous years the mortality rates were: 1916, 14.08; 1915, 15.71; 1914, 14.41; 1913, 14.64; 1912, 14.13; 1911, 15.32; 1910, 16.96; 1909, 16.26; 1908, 17.39; 1907, 16.01; 1906, 17.20; 1905, 16.36; 1904, 17.14; 1903, 13.73, and 1902, 14.74. The average annual mortality for the period from 1902 to 1917, inclusive, was, therefore, 15.53 per thousand.

Ages.—Of the decedents, 55 were between the ages of 21 and 30; 178 between the ages of 31 and 40; 367 between 41 and 50; 449 between 51 and 60; 503 between 61 and 70; 431 between 71 and 80; 170 between 81 and 90, and 27 between 91 and 100. The greatest mortality occurred at the age of 61, when 63 deaths were recorded.

Causes of Death. — There were 191 deaths assigned to general diseases; 246 to diseases of the nervous system; 296 to diseases of the circulatory system; 208 to diseases of the respiratory system; 86 to diseases of the digestive system; 115 to diseases of the genito-urinary system; 388 to senility; 31 to suicide; 111 to accident; 23 to homicide, and 66 after surgical operation. Among the principal assigned causes of death are senility, 388; heart diseases, 202; cerebral hemorrhage, 195; pneumonia, 189; accident, 111; nephritis, 86; surgical operation, 66; tuberculosis, 44; malignant disease, 40; suicide, 31; arteriosclerosis, 30; angina pectoris, 29; septicema and homicide, each, 23; diabetes, 22; uremia, 17; gastritis, myocarditis and appendicitis, each 16; intestinal disease (unclassified) and influenza, each 14; anemia and typhoid fever, each 13; meningitis and brain disease (unclassified), each 11; influenza, nervous disease (unclassified) and kidney disease (unclassified), each 10; erysipelas, 8; endocarditis, choleiithiasis and peritonitis, each 7; embolism, asthma and respiratory diseases (unclassified), each 6; neuritis, gastric ulcer and liver disease (unclassified), each 5; rheumatism, leukemia, bronchitis, cirrhosis of the liver and dilatation of the heart, each 4; dysentery and spinal disease (unclassified), each 3; malaria, diphtheria, paresis, general paralysis of the insane, pleurisy, hernia, intestinal obstruction, duodenal ulcer, prostatitis and dropsy, each 2, and 1 death from anthrax, pellagra, chronic articular rheumatism, insanity (unclassified), paralysis agitans, anterior poliomyelitis, ear disease (unclassified), mastoiditis, aneurysm, lymphatic disease (unclassified), pulmonary emphysema, and purpura hemorrhagica. One physician died in prison, and seven medical officers lost their lives in battle.

The causes assigned for the 111 deaths from accidents were: automobile, 41; falls, 11; railway-automobile (grade crossing). 9; railway, 9; drowning, 10; firearms, 8; poison, 4; burns, 6; sunstroke, 4; freezing, 1; lightning, 1; explosion, 1; electricity, 1; machinery, 1; horses and vehicles, 1; other accidental traumatisms, 3, and suffocation, 1. The 31 physicians who ended their lives by suicide selected the following methods: firearms, 15; poison, 5; hanging, 2; cutting instruments, 3; drowning, 1; jumping from high places, 1, and other means, 4. Of the 16 homicides, 11 were due to firearms; 2 to cutting instruments, and in 3 the method was not reported.

The chief death causes in the order named were senility, heart disease, cerebral hemorrhage, pneumonia, accident, nephritis and surgical operations. The age at death varied from 21 to 100, with an average of 60 years, 8 months, 13 days. The general average of age at death since 1902 is 59 years, 9 months and 2 days. The number of years of practice varied from 1 to 70 years, the average being 32 years, 7 months and 1 day. The average for the past thirteen years is 31 years, 2 months and 11 days.

Military Service.—During the year, 215 peysicians died who had served in the Civil War; of these, 59 had followed the fortunes of the Confederacy, and 61 had been medical officers of the United States Volunteers. The Medical Corps of the Army lost 10 officers; the Medical Reserve Corps, 20; 15 had been contract or acting

assistant surgeons, and 2 were medical cadets. The Navy lost 14 medical officers; the Public Health Service, 7; the Indian Service, 8, and the organized militia, 31, of whom 5 had attained the grade of Surgeon-General.

Civil Positions.—Of those who died, one had been a member of Congress; one, the governor of a state; one, an ambassador; 11, members of state senates; 34, members of the lower houses of legislatures; 38 had been mayors.

Association Fellowship.—Of the 689 Fellows of the American Medical Association who died during 1917, two had been vice presidents; one, a member of the House of Delegates; two, members of the Committee on National Legislation; one, a member of the Council on Pharmacy and Chemistry, and one, a member of the Board of Trustees.—Journal A. M. A., Jan. 5, 1918.

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Blood Pressure in Obstetrics.

J. L. Slemons, New Haven, Conn. (Jour. A. M. A., Sept. 8, 1917), summarizes his observations of the value of blood pressure observations in pregnant women substantially as follows: Blood pressure observations afford the means for the early detection of pre-eclamptic toxemia and the severity of the auto-intoxication, and also are useful occasionally in the differentiation of pyelitis from the albuminuria of pregnancy. They also give a measure of the efficiency of treatment of active eclampsia and a method of obtaining the ultimate prognosis in these cases. When patients are carrying a double burden of chronic valvular heart trouble and toxemia, knowledge of the blood pressure is indispensable as a therapeutic guide. Since knowledge is also required from estimating the work the heart is doing, by this means we shall probably obtain a more timely method of recognizing the approach of a breach in compensation in chronic valvular heart disease, and therefore be able to decide the question of the induction of labor as a prophylactic. He has tried the use of lumbar puncture in five cases of eclampsia, as reported on by Wilson, and considers that while it may not be implicitly relied on to check or modify the convulsions, it adds another therapeutic measure to our arsenal. In two desperate cases immediate improvement followed the measure.

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Insolubility of Gelatin Capsules.

F. W. Dershimer, British Guiana (Jour. A. M. A., Nov. 3, 1917), remarking on the task of making drugs palatable thinks we may overdo the matter. Experiments seem to prove that soft gelatin capsules may protect the drugs from the action not only of the saliva but from the gastric and enteric juices. He has experimented with both hard and soft capsules in a pepsin solution slightly acidified with hydrochloric acid. The hard capsule completely dissolved in about twenty-one minutes, but the soft capsule showed no signs of dissolving after twenty-four hours. Recently the writer's attention was again called to the matter by a memorandum from Walaya Health Board which reported that the soft gelatin capsules were not easily soluble and showed a decrease in their efficiency in the treatment of hookworm. He then repeated his experiments, which gave similar results and seemed to indicate that drugs should not be administered in soft gelatin capsules with any hope that they will act efficiently.

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Intubation of the Larynx

H. J. Cartin, Johnston, Pa. (Journal A. M. A., Aug. 11, 1917), gives an analysis of 350 cases of laryngeal intubation occurring in his private practice in a region largely inhabited by foreigners living under unsanitary conditions and inclined to conceal disease through fear of quarantine, and where naturally epidemics of diphtheria are common. The analysis is rather elaborate, but his conclusions from it are given as follows: "1. No patient needing intubation should be denied the chance to live because of lack of hospital facilities. 2. Overcrowding of homes, unhygienic surroundings, concealment of disease, and exposure to contagion are re-

sponsible for the epidemics. 3. Lack of trained assistants need not deter one from operating. 4. The use of a tube larger than that indicated for a given age gives better results. 5. Early intubation with large doses of antitoxin reduces the mortality. 6. Wearing the tube five days resulted in fewer reintubations. 7. It appears that special diet and methods of feeding are unnecessary. 8. Reintubation does not seem to affect phonation permanently."

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Pericardium

A comparison of the compression and Roentgen-ray findings after injection of the pericardium, made after experimental work with fresh human cadavers, is reported by R. S. Morris and Ellis R. Bader, Cincinnati (Journal A. M. A., Aug. 11, 1917). Experiments and methods are described with special reference largely to the question of presence or absence of an obtuse cardiohepatic angle. The findings are summed up in the following: "Our findings in fresh cadavers show that retrosternal dullness, with increasing retrosternal shadow in roentgenograms, is a relatively early phenomenon after injection of the pericardium with serous fluid, and suggest that shifting retrosternal dullness (loss or marked decrease in dullness, with decrease in the shadow of the fluoroscope or in plate) may be a relatively early sign of pericardial effusion. With fluid under great pressure in the pericardium on the other hand, marked shifting dullness will probably largely disappear." The article is illustrated.

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Diabetes.

A. C. Crofton, Chicago (Journal A.M.A., December 8, 1917), believes that in mild cases of diabetes and in those of medium severity, the rigorous starvation plan of treatment is ineffective and, in some cases, more dangerous than the old methods. As to tolerance, in the milder cases he has never seen an increase in tolerance for carbohydrates, finding it, on the contrary, usually reduced. The excretion of acetone bodies to an alarming degree is liable to take place in this type during starvation or after the resumption of carbohydrate feeding, though in the hospital this, as a rule, can be regulated. As an emergency measure, the method is useful. Starvation, however, is usually employed by the general practitioner who, being outside an institution, has not the facilities to learn the technic of controlling these cases, thinks it is easy to foresee possibilities of danger. Edema, when occurring in diabetes, he considers a symptom due possibly to the starvation treatment. It is a danger signal of coma and is due to retention of water when the starvation treatment is used. When it occurs, it is a sign to resume feeding. The use of sodium bicarbonate in large doses leaves the patient, as far as his tolerance is concerned, in a worse condition than before the starvation plan was inaugurated.

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Recurrent Laryngeal Nerve Paralysis.

G. E. Brown and B. E. Hempstead, Miles City, Mont. (Journal A.M.A., January 5, 1918), report a case of recurrent laryngeal nerve paralysis associated with mitral stenosis. The usual association of this paralysis is with aneurysm and aortic arch dilatation, and it is only since Ortner's original report in 1897 that we have learned that recurrent paralysis may be associated with and apparently caused by cardiac enlargement. In a series of 360 cases studied by Thompson, in St. Clair, only ten were reported as being due to an enlargement of the heart in mitral stenosis. Up to 1916 only eleven cases had been reported with necropsy confirmation, but a number of clinically reported cases with a recurrent paralysis have been reported in which the cardiac condition could be proved the causative agent. The proof has become more exact since the advent and general use of the roentgen ray in chest diagnosis. It was used in the writers' patient, and they comment on it as follows: "This was a case of mitral stenosis, associated with temporary paralysis of the left re-

current nerve during a period of mild decompensation, in which, under appropriate treatment, the left auricle increased in size. This reduction in the size of the auricular chamber evidently released a pressure on the left recurrent nerve with restoration of its function. The case is the only one of this particular type that we have been able to find in which a diagnosis could be made early enough to allow the nerve function to return. The case illustrates the importance of a rigid investigation of every case of left laryngeal paralysis to rule out its more common causes, as no other etiology offers a better chance of relief than this particular type."

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Pneumococcus Carriers.

Recent studies on the epidemiology of lobar pneumonia show that it arises by infection from without, the pneumococci being transferred from other individuals. In studies of a large number of healthy persons who have been in contact with pneumonia due to Type I or II pneumococci, it has been found that about 12 per cent were carrying pneumococci of the corresponding types. J. A. Kolmer and Edward Steinfield, Philadelphia (Journal A. M. A., January 5, 1918), review the literature of pneumonia carriers, declaring that it would seem advisable to attempt the destruction of pneumococci in the mouth secretions of convalescents and healthy persons who have been in contact with patients. Wadsworth has already tested the disinfecting power of saline solutions and bland alcoholic washes. European and American investigators have shown the high pneumococcidal activity of ethylhydrocuprein hydrochlorid as found by Kolmer and Heist. Other cinchonics, such as quinin and urea hydrochlorid and quinin bisulphate, also possess considerable pneumococcidal powers. The writers, therefore, in this article report their experiments on this disinfection of sputum and the mouth by these various cinchonics in a menstruum of liquor antisepticus.

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Their experiments demonstrate that the latter solution alone, in dilution from the proportion of 1 to 4 to the propertion of 1 to 10, possesses some germicidal activity for pneumococci, and also aids in disguising the bitter taste of cinchona compounds. The results of their experiments with the sputum have indicated that dilution of ethylhydrocuprein hydrochlorid as high as 1 to 30,000, and even to 1 to 160,000, had appreciable and frequently well-defined effects, while a 1 to 10,000 dilution almost invariably disinfected sputum containing pneumococci. The other conchonics in solution varying from the proportion of 1 to 10,000 to the proportion of 1 to 20,000 were also found to possess definite disinfectant qualities. Many trials have convinced the writers as to the disinfecting value of the substances mentioned. Since the fact has been established that a considerable percentage of convalescents and persons who come in contact with lobar pneumonia become carriers, the writers would advise the clinical trial of these disinfectants in the patients themselves, and on patients suffering from measles or other diseases favoring the development of lobar pneumonia. The systematic use of 1 to 10,000 solution of ethylhydrocuprein hydrochlorid in a 1 to 10 dilution of liquor antisepticus twice or more daily is not dangerous from the standpoint of toxicity due to swallowing portions of the drug. Nor is it unpleasant, and it may aid in ridding the mouth of virulent pneumococci. Since this drug is scarce at present, the other cinchonics may be substituted, though these are less powerful pneumococcicides. Similar dilutions of undiluted Dobell's solution may be used for douching or spraying the nose or may be incorporated in a dental cream for use on the teeth.

Emetin in Cancer.

There are some observers, especially among clinicians, says Richard Lewisohn, New York (Journal A. M. A., January 5, 1918), who hold the belief that the etiologic factor in malignant neoplasms is

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amebic. The possibility of this suggested to him the trial of the alkaloid emetin in cases of human cancer. The present paper is due to the report by Dr. Mary Freeman that she had used emetin locally with seeming success in cancer. The writer reports two operations for cancer, in which local injections of emetin were tried. The local symptoms were promising at first, but one of the patients died from an internal metastasis. The other seems to be in perfect health, but the roentgen ray shows a shadow in the lung. Animal experiments were made on rats and mice. The injected cancers showed necrosis and scab formation, and in the majority of cases the scab fell off after a week, leaving an indurated area. Microscopic examinations showed practically a total absence of tumor cells, evidently due to the cell-destroying action of the emetin. In other experiments it was shown that the injections of the fluid into the tumor had no effect in producing the results. His conclusions are given as follows: "1. Injection of emetin into carcinoma and sarcoma may cause a complete macroscopic disappearance of most of the tumors. This disappearance is not due to a specific action of emetin on the tumor cells. The action of the drug is purely caustic, similar though in less degree to the action of phenol (carbolic acid), zinc chlorid, etc. 2. Repeated intravenous injections of emetin do not effect the growth of carcinomas and sarcomas. This proves conclusively that emetin has no specific effect on the growth of malignant tumors. 3. These observations do not strengthen the amebic theory of malignant tumors."

B

Neodiarsenol.

E. P. Zeisler, Chicago (Journal A.M.A., December 29, 1917), discusses a recent series of twenty intravenous injections of neodiarsenol, a recent substitute for neosalvarsan marketed by a Canadian firm, which he gave to patients in all stages of syphilis. He observed an unusually large percentage of severe reactions, such as fever, headache, vertigo, vomiting, nausea,

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faintness, thoracic oppression sometimes extremely alarming, at least it was in one case. On account of his unpleasant experiences in the use of neodiarsenol, he has ceased to use it and has since employed the French preparation, novarsenobenzol (Billon), which has given satisfaction.

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Vital Capacity and Heart Disease.

C. W. McClure and F. W. Peabody, Boston (Journal A.M.A., December 8, 1917), call attention to the importance of a decrease in vital capacity of the lungs as a factor in the production of dyspnea in heart disease. The degree of decrease of vital capacity below certain normal standards corresponds closely to the tendency to dyspnea. Since this tendency depends largely on the functional capacity of the heart, the determination of the vital capacity of the lungs may serve as an indirect index to the cardiac condition. This has been determined by the authors in a series of twenty-four cases, as shown by the tables which the writers present. Improvement in the functional state of the heart is associated with a rise in the vital capacity. When the heart condition is apparently stationary, changes in the pulmonary vital capacity are not marked and when there is evidence of increasing cardiac insufficiency the vital capacity of the lungs also fails. Charts showing the variations in the vital capacity of the lungs of patients with heart disease are frequently satisfactory objective records of the clinical course of the disease and may be an aid in prognosis.

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Doctor—"Have you been the victim of an assault?"

Patient—"Oh, no, sir. I simply fainted and was brought to by a Red Cross Nurse's Voluntary Aid."

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Help the Doctor.

First Voluntary Aid—"This patient's temperature is 105 degrees. That's awfully high, isn't it? What shall I do?"

Second V. A.—"Put him down 100. The doctor gets so nervous if it's more."

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Freudian Psychology.

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Read before the Shawnee County Medical Society.

This paper is merely an effort to show that the Freudian theory is not something unique, bizarre or different from the science of biology, but on the contrary it is quite in keeping with modern physiology in considering man as an adaptive mechanism. Nothing original is claimed; in fact, the chief claim this paper has to your consideration is that it is merely a compilation from books and technical magazines written by people whose extensive work and experiments entitle them to a hearing. Except where condensation was necessary, the exact wording of the author has been preserved in order that the meaning may not be distorted.

For years past we have been observing the symptoms of mental disease and perfecting a classification based thereon. This is good as far as it goes. It is good to know typhoid fever, diphtheria and malaria as clinical entities and to know how to treat them to get the best results, even though that treatment be purely empirical. But it is far better, both from a practical and scientific standpoint, to know their etiology. And so it is with mental diseases. We wish to know the specific causes operate. How far we are from this causes producing them, and just how these ideal state of affairs may be shown by the various theories put forth by their enthusiastic advocates. True, we know that brain changes resulting from syphilis may give us dementia paralytica, simple syphilitic dementia, pseudo-paresis, or a tabetic psychosis; and that brain tumor and abscess and apoplexy and cerebral trauma give us their characteristic symptoms and signs, that alcohol and certain drugs give us the intoxication psychoses, and that hardened arteries and senility induce mental changes corresponding with the physical brain changes. But there still remain the neuroses and the psychoses which present no characteristic brain changes to account for the mental changes in such diseases as manic-depressive insanity, paranoia, neurasthenia, hysteria, anxiety and obsessional neuroses, and perhaps the early stages of dementia præcox.

Are these diseases somatogenic or psychogenic?

Some advance a theory of a disordered secretion of the ductless glands, others a disturbance of metabolism, or some other vague terms as mental or physical strain, and one paper even goes so far as to connect mental disease with a disturbance of kidney function!

On the other hand there has grown up a school of investigators who are conceiving life as a dynamic force and are approaching the problem from the psychic side; pre-eminent in this class is Sigmund Freud. Some of Freud's followers think of him as a second Darwin, claiming that he has done for the mental life what Darwin did for the physical; others are bitter in their denunciation of him, which argues nothing against his theories but merely shows that he has come in conflict with the traditions of the race or touched a complex of the individual.

But before looking at Freud's theories, let us get rid of the idea of the dual nature of man and consider him as a biological unit. Let us also note that some of our greatest scientists consider an idea not as something spiritual and apart from the physical, but as a dynamic force which reacts on the physical.

Sherrington traces the integration of the nervous system from the simple reflex arc to the complex co-ordinations of the brain and concludes that the cerebral cortex is the organ of and for the adaptation of nervous reactions.

"The child is born into the world with no mind, no consciousness, but with a central nervous system and special sense organs." From the moment of its birth it begins to receive sensations from the outer world and react to them, and the manner of its reaction is the result of the adaptation of its progenitors, through natural selection, throughout the eons required to evolve the species. As William A. White, of the Government Hospital for the Insane at Washington, so clearly puts it,

"In no other way can the stuff out of which the mind is made find its way to the brain except by the sensorium. Whatever man may become must, in the last analysis, depend upon this material, and so no conception of mind can fail to take it into account. A person at any particular moment is the end result of all the processes that have been at work since his conception and in the same way a given state of mind can only be conceived to be what it is because of all that has gone before—it is the end product."

Loeb, in his "Mechanistic Conception of Life," has shown how certain insects must go to the light even though it means their destruction because of their light tropism. After numerous experiments with physical and chemical changes in animals he says:

"I believe that the investigation of the conditions which produce tropisms may be of importance for psychiatry. If by means of an acid we can call forth in an animal otherwise indifferent to light a heliotropism which drives it irresistibly to a flame; if the same thing can be brought about by means of a secretion of the reproductive glands, we have given, I believe, a group of facts, within which the analogies necessary for psychiatry can be called forth experimentally and can be investigated.

"These experiments may also attain a similar value for ethics, namely, the condition that human beings are willing to sacrifice their lives for an idea is comprehensible neither from the utilitarian standpoint nor from that of the categorical imperative. It might be possible that under the influence of certain ideas chemical changes, for instance, internal secretions within the body, are produced which increase the sensitiveness to certain stimuli to such an unusual degree that such people become slaves to certain stimuli, just as the copepods become slaves to the light when carbon dioxide is added to the water."

Since Powlow demonstrated in his experiments on dogs that gastric juice could be caused to flow by means of optic and acoustic signals which had formerly been associated with feeding, it no longer seems strange to us that what the philosopher terms an idea is a process which can cause chemical changes in the body. This response to an associated stimulus is called a conditional reflex and is made use of by all animal trainers.

Cannon, professor of physiology at Harvard, shows us the effect of the emotions on digestion, also on adrenal secretion and the liberation of blood sugar, and how these latter in turn raise the blood pressure and also increase muscular contraction, counteract fatigue, and hasten the coagulation of the blood. He shows us the utility of the emotions in great crises, in competitive sports, and in battles. He also calls attention to the fact that emotions must have an outlet, and that nervous strain and restlessness due to a baulked disposition may result from the absence of circumstances which would call the emotional responses into action.

It has remained for Crile to give us the most complete picture of man as an adap-

tive mechanism. By extensive experiments he has found that fear, traumatic injury and the exertion of running or fighting produce the same histological changes in the brain, the adrenals and the liver. It is obvious, therefore, that these three types of exhaustion are similar, the difference being that fatigue from physical exertion results from the integration of the motor mechanism with complete response in activity or obvious work performed; while shock or exhaustion caused by emotion results from an integration of the nervous mechanism without obvious work performed. In the latter case the exhaustion is comparable to the effects produced in an electric automobile which has been integrated to go ahead by a closed circuit, while the wheels of the machine are held immobile.

According to Crile, "The brain is the initiator of response, being activated by the environment within or without the body; acting like a storage battery, it contributes the initial spark and impulse which drives the mechanism.

"The adrenals act as oxidizers, making possible the transformation of energy and the neutralization of the resulting acid products.

"The liver is the chief fabricator and storehouse of the carbohydrate fuel by which muscular action and heat are produced. The liver also plays a large role in the neutralization of the acid products of the transformation of energy.

"The muscles are the engine or motor in which is consummated the final step in the transformation of energy into heat or motion.

"The thyroid by supplying a secretion which facilitates the passage of ions would seem to be the organ of speed control governing the rate at which the transformation of energy is effected."

And these organs which bear the brunt of the transformation of potential into kinetic energy and the neutralization of the consequent acid by-products and have been evolved for that purpose are termed by Crile "the kinetic system."

Summing up Crile's mechanistic conception of the universe with man as an adaptive mechanism we may say that the child comes into the world with a definite inheritance due to mechanistic conditions. He may be a normal healthy child or he may be stunted from the mother's lack of certain salts or of iodine, or the poisons of syphilis or excessive emotion. Whatever his inheritance, he struggles to adapt himself to his environment in infancy, in childhood, and during adolescence. He transforms energy at the incidence of adequate stimulus in accordance with phylogenetic and ontogenetic association, or memory into acts. His kinetic system is driven by injury, by emotion, and by infection, and many diseases result from his struggle with his external and internal environment.

The history of the race has been the history of adaptation to environment from life in the trees to the use of tools and fire and shelter and means of communication. As man became more and more completely adapted to his environment, his numbers increased until in his desire to possess the earth he found his most formidable enemies to be his fellow men; hence, we see this human animal prone to kill because his evolution has depended upon his ability to conquer brute animals and his fellow man. We see that his two most complete adaptations are those of killing and procreating — the inevitable sequel of the primal needs of self preservation and for the preservation of his species.

"The most powerful activator of the kinetic system of man today is his fellow man. This is the enemy he most fears. In the midst of plenty he strives for more. He is at war with his fellows in business, in education, in the arts, in the professions, in philanthropy, and in winning mates. There is no game nor sport that is not a battle. Even the toddling child, when pursued, turns at bay when captured; an obvious recall of the bloody abyss of phylogeny, since all animals turn for the final death struggle. In all his waking moments and even in his dreams,

man exerts himself against his fellows. He fears; he hopes; he triumphs; he is vanquished; he is jealous and suspicious. Yet with all his fears and struggles, he is forever bound to his fellows by the chains of necessity, for he cannot succeed alone. Man is of necessity a gregarious animal. He hates and fears, while at the same time he is grateful and dependent. The rivalry and jealousy of his life turn to grief at the death of his rival. And in these emotions and strivings are laid the foundations of many diseases. These antithetic relations between individuals are exhibited on a vast scale by nations in mutual dependence, mutual help, mutual jealousy, mutual hate and mutual efforts to kill. The effect of fear, grief, worry and jealousy on the physical body is seen in the changes in the cells of the brain, the adrenals and the liver in the numerous resultant diseases and disabilities. Against man's inhumanity to man, religions and philosophies have been evolved, each of which aids in proportion to its power to substitute faith for fear, to substitute altruism for selfishness."

"Excessive anger, work, jealousy, envy, worry or grief cause physical damage as serious as that produced by infections or crushing blows."

Now turning from Crile the scientist and surgeon, to Freud, the scientist and psychologist, and remembering that the most powerful activator of the kinetic system of man today is his fellow man, and that fear, worry and hate affect the physical system, let us briefly consider the theories of Sigmund Freud.

Previous to Freud, Mesmer, Braid, Janet, Sidis, Prince and White had worked on the problems of dissociation, hypnosis and hysteria, but Freud was the first to formulate an hypothesis which considered that each psychic event had a history, and which has led to the same recognition of the value of the past of the psyche as has been for so long accorded to the past of the body in the sciences of embryology and comparative anatomy. "This past does not have only a temporal significance, but as in the sciences of embryology and comparative anatomy, a much greater significance expressed in terms of developmental progress. To understand, therefore, the meaning of a given psychic event, means that the problem of its meaning must, quite as in the case of the body, be approached from the genetic point of view."

The central feature of the Freudian system is the conception of mental conflict. From an early period of life the child finds the gratification of its instinctive impulses checked or even prevented by the pressure of its environment. Conflict is thus set up between the two forces of instinctive pressure within and social pressure without. Instinctive forces which thus come into conflict with the repressing or social force are not destroyed but are deflected from their natural outlet, are repressed within the mind and ultimately prevented from rising into the conscious field at all except in disguised or symbolic forms. To the adult his childhood seems to have been altogether free from any kind of sexual activity or interest, not because, as is generally supposed, such has never existed, but because it has proved incapable of persisting in the conscious field and was suppressed into the unconscious with the increase of social repressing forces.

Similar impulses experienced in adult life which are for the same reason incompatible with conscious recognition do not become conscious, but live their lives in the unconscious, though they may exercise the profoundest influence on the happiness and health of the subject.

Right here it may not be amiss to note that in this conflict between the instinctive impulses of self-preservation and sex on the one hand and the social repressing force on the other, Freud has concentrated his attention on the former, though fully recognizing the potency of the latter, and it has remained for Trotter, of London, to show us that any force which can take the immensely powerfust instinct of sex and mould and deform its prodigous mental energy must in itself be a powerful instinct, and he calls it the herd instinct,

for man is a gregarious and not a solitary animal, and he possesses a specific sensitiveness to environmental influences.

True conflict which moulds and deforms must be actually within the mind—must be endo-psychic, to use a term invented by Freud.

In order that a desire may set up conflict, it must be thwarted, not by a plain impossibility or by mere physical pain, but by another impulse within the mind antagonizing it. For instance, a child may have certain desires which he cannot gratify because of a physical impossibility. This establishes no conflict because the resistance is wholly external, and the whole child still desires its pleasure and its whole resources, mental and physical, are directed to gain the object. Or in another instance the gratification may prove physically painful in itself, as when the child burns its fingers in securing a desired object. But the source of this pain is external and the only emotional quality is that of its unpleasantness, and this cannot enter into the child's mind and divide it against itself.

Thus we see that the essence of mental conflict is the antagonism of two impulses both of which have instinct behind them. Thus only can the mind become a house divided against itself.

Freud lays little stress on any conflict due to repression of the instinct of self-preservation, but that is because society allows a normal expression of that instinct and any repressions necessary are explained to and understood by the child, whereas the repression of the sex instinct is manifested, as Trotter says, "not merely in direct precepts, in warning, in punishment, in expressions of disapproval or disgust, but in a whole system of secrecy, of significant silences, of suppressions, of nods and winks and surreptitious signallings, of sudden senseless snubs and patently lame explanations amid which such sexual interest as the child possesses has to find a modus vivendi and an intelligible meaning."

This brings us face to face with the question of why the sex instinct is suppressed, and we turn not to ethics but to biology for our answer. The powerful sex instinct in its primitive form produced eggs and sperm. In the process of development, a part of this instinct was diverted from its original destination and a definite quantity was used up in the mechanisms of mutual attraction and protection of offspring. Still later in the process of evolution primitive races dimly discerning that certain things were not good for the tribe, established taboos. These taboos form the basis of many customs and may become incorporated in a religion. So society, faintly conscious that a small amount of the sex instinct served for the preservation of the species, established a taboo on its exercise except under certain conditions and limitations, and thus the rest of this energy is diverted from its original aim and becomes a creative force for the good of society. It is to this sublimation of the sex instinct that we owe all our art, our music, our poetry, our religion. Small wonder is it then that Nature, caring only for the progress of the race and indifferent to the welfare of the individual, demands of the individual that he curtail the gratification of his instincts and devote the energy thus saved to the upbuilding of this complex creation we call civilization.

This repressed sexual instinct betrays itself by a feeling of impropriety or disgust when the subject of sex is made a matter of discussion and affords an excellent example of a defence mechanism. If there were no repression, the discussion of a sexual subject would be of no more interest nor arouse any more emotional reaction than the subject of digestion.

Now a word in regard to what is meant by the unconscious. The unconscious in the Freudian sense does not mean something that is merely out of the focus of attention for the time being and is capable of voluntary recall. It means something which one does not really know, but is compelled in the analysis by conclusive inferences to recognize. No better exam-

ple of this can be obtained than what occurred in this hospital some years ago when the campaign for woman's suffrage was on. I was an enthusiastic advocate of suffrage and the men of the staff were just as ardently opposed—or said they were. At the same time, two of our staff were interested in hypnotism, and Doctor No. 1 hypnotized Doctor No. 2 and told him that at 11 o'clock the next morning he was to go into the front office, take a book from the bookcase and lay it on my desk. At 11 o'clock Doctor No. 2 appeared in the front office, walked about the room, stopped in front of the bookcase, selected a book on mental diseases, threw it on my desk and said, "There, if you would devote more of your time to studying that book and less to talking suffrage, it would be better for you." Of course we gave him the laugh and gave him the explanation of his actions, but even then he had absolutely no memory of what had occurred during the time he was hypnotized. Now if the commands of the hypnotizer can drive anything completely from the consciousness of the individual, does it seem very hard to believe that when the whole force of the psyche is exerted to repress a wish or emotion it can be driven into the unconscious beyond all power of the individual to recall?

This experiment illustrates another thing, and that is that we are actuated by motives of which we are unconscious. Doctor No. 2 was impelled by a force he knew nothing about to lay that book on my desk, but he explained the impulse as a philanthropic desire to advise me for my own good, and he fully believed in his own explanation. This is called the process of rationalization. We are actuated by motives of which we are unconscious, but our explanations are in accordance with our ideas of what is right and proper. This lets us do what we want to do, but by assigning the proper motive permits us to retain our good opinion of ourselves. A good example of this is seen in the so-called good men and women who enjoy a scandal. They fear to do anything improper, yet they gratify their erotic and vicious desires by repeating the delicious morsel of scandal while at the same time preserve an exalted idea of their own goodness by professing a horror of what has been done. Were the bad things really abhorrent to their unconscious selves, they would neither read nor repeat them.

Another term in frequent use in Freudian literature is the complex. A thought complex is a system of ideas or associations with an especially strong emotional tone. For instance, a young man in love will be more acutely attuned to anything touching on the subject of love or domesticity than one who is not. Also, a person who is much interested in politics and has been strongly identified with a political party will find it hard to look at any proposed measure absolutely on its merits. We used to say he had a party bias, now we say he has a political complex.

Personality may be defined as a collection of unified complexes existing together and constituting the individual mind. In order to eliminate conflict, an idea incompatible with our beliefs or training may be rationalized, which as we have seen is often a species of sophistry which allows us to continue a course of action out of harmony with our ideals, or the conflicting complex may be repressed. Now if this complex is successfully repressed and its energy sublimated, we have no symptoms, no neurosis. But often the instinctive desires are too strong for our social conscience, and the repression is only partially successful. When a thought complex is repressed because of its incompatibility with the better part of the personality, and its intellectual content is forgotten by the active working mind, its emotional tone remains in the under mind unsynthetized with the personality as a disassociated or segregated bit of mind. Because of its intellectual content (for instance the desire for another's wife) is not acceptable it is turned down and not known to exist, but none the less it is active and *something must become of its energy.*

Freud points out that here is to be found

the cause of the mental and physical symptoms which we are called upon to treat in the psychoneuroses. The headaches, confusional states, faints, epileptiform seizures, tics, obsessions, phobias, impulsions, spasms, and paralyses are all dependent upon the displacement of this conflicting disassociated energy into neutral paths that happen to be open and hence offer the least resistance to the spurious energy which has failed to find its outlet through normal synthesis with the rest of the conscious personality and hence has become diverted into some of these less resistant channels and converted into symptoms.

Let us take an example. "Suppose our patient to be an esthetic young man of high ideals. At a watering place one summer he meets a charming young woman whom he learns to love. He has about made up his mind to propose when he is unexpectedly introduced to her husband (psychic trauma). All the associations and desires which go to make up his love complex have suddenly become incompatible with his ideal of manliness and must be forgotten (repression) if he is to live at peace with himself. At the time of introduction he had walked to the depot in the sun after a large meal, and so had some palpitation and a slight headache, the engine was making a distracting noise (accidental moment). He succeeds in forgetting to thing of the young woman in the light of a lover but he gradually develops a chronic headache, palpitation, dyspepsia and a dread of noises and trains, slight walks produce fatigue (all symbolic displacements dependent upon the channels of least resistance at the time of the psychic trauma). The love complex has become split off from the rest of his personality, it has become a disassociated personality, or a parasitic consciousness, and this mental conflict has caused temperamental changes, he is moody, irritable, sleepless, etc."

Now if this seems far fetched, let me remind you it is only a complicated case of the conditional reflex before noted. It is no more unreasonable that the man should develop a dread of noises heard at the moment of his psychic trauma, than that the dog should secrete gastric juice in response to the blowing of a whistle merely because that whistle has previously been blown when he was fed.

Further, this young man dreams and in his dreams the desires which he was unable to fulfill regarding his sweetheart will there be lived out in phantasy (wish fulfillment).

The psychoanalysts have come to place much importance upon dreams. They have found that the mind uses dream life to fulfill wishes and yearnings that are impossible of fulfillment with the social or ideal consciousness.

These dreams are often strangely disguised or distorted, and above all symbolic. Freud says that the stimulus to a dream is invariably some incident of the day preceding, and that starting back from this idea this chance association may be traced back thread by thread to the wish by taking each dream thought separately and having the patient in the waking state tell all the words or ideas associated with it.

One always meets the objection that dreams can't be wish fulfillments because they are often unpleasant, but let us remember that the wish manifested in the dream always originates in the unconscious. Conscious wish is a dream inciter only if it succeeds in arousing a similar unconscious wish which reinforces it. Now the unconscious is the instinctive or infantile desires, and the infantile mind is always egotistical. Every dream is absolutely egotistical; in every dream the beloved ego appears, even though it may be in the disguised form. This disguised form is made necessary by the social conscience or censor. As long as the disguise is complete there is no fear, but when the censor is partially or entirely overcome and the conflict in the mind is aroused we have fear. In other words, the distortion in dreams is to prevent fear and other forms of disagreeable emotion. The overpowering of the censor is made easier when fear has already been furnished by

stimulation from somatic sources, as in cases of persons suffering from pulmonary or heart disease where there is occasional difficulty in getting the breath, but even in these cases the somatic stimuli are used to aid those energetically suppressed wishes in attaining fulfillment in the form of a dream, the dreaming of which from psychic motives would have resulted in the same release of fear.

Closely related to fear dreams are anxiety dreams. Anxiety in dreams may be of a psycho-neurotic nature or it may originate in psychosexual excitements, in which case the anxiety corresponds to a repressed libido. Then this anxiety, as well as the whole anxiety dream, has the significance of a neurotic symptom, and we are at the dividing line where the wish-fulfilling tendency of dreams disappears.

Now just a word in regard to psychoanalysis. It may be defined as the reduction of an actual conscious content of a so-called accidental nature into its psychological determinants. It is not simply a deep and complicated form of anamnesis, it is not suggestion, it is not a method of reasoning with the patient.

Psychoanalysis endeavors to overcome the disorders of the neurotic through the subconscious and not through the conscious self. The patient himself does not know of the trouble existing in the subconscious and it must be revealed to him through a process of association requiring much study, much time and an infinite amount of tact and patience.

At the present stage only the true neuroses—neurasthenia and anxiety neurosis —and the psycho-neuroses—hysteria and obsessional neurosis—have been found suitable for this treatment. Whether such treatment will become applicable to the early stages of the psychoses remains to be seen.

In the meantime the studies of the neurotic and insane throw much light on the mental processes of the sane, for the mental mechanisms are the same. Just as we now view diseases of the body as a reaction to, say, an injury or an infecting organism, so we view mental disease as a reaction of the loosely knit neuropathic mind to conflicting emotions and desires.

The normal mind deals with the conflict between the pleasure-pain principle and reality in the full light of consciousness, and strives to adjust itself to reality; whereas the neuropathic mind suppresses into the unconscious the unpleasant facts and strives to obtain pleasure by regression to lower levels—to the infantile mode of dealing with life which is to find in phantasy what it misses in reality.

But it is not alone in the neuroses that psychoanalysis is applicable. It can be applied to normal individuals and thus establish a basis for the understanding of human conduct. It can be applied to the developing child and have as great a field in the prevention of psychic disorders and social ills as preventive medicine has had in the prevention of small-pox and malaria.

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The Relationship of Gastric Ulcer to Malignancy.

ALBERT SMITH, M.D., Parsons, Kansas.

Read before the Kansas Medical Society at Salina, Kansas, May 2, 3 and 4, 1917.

In discussing the relationship of gastric ulcer to gastric cancer, some authorities claim that gastric cancer never originates from gastric ulcer, while others claim gastric ulcer is a favorite habitat for the development of gastric cancer. Be that as it may, gastric cancer may originate from any irritation in the stomach.

In order to take up the differential diagnosis of gastric ulcer from gastric cancer and their relation to one another it will be necessary to give a few diagnostic symp-

toms of each. We will first discuss gastric ulcer.

Gastric ulcer is a very frequent and very fatal disease. Statistics would seem to indicate that nearly 25 per cent of both acute and chronic ulcers of the stomach, taken together, untreated surgically, are fatal. Of these 6 per cent die of perforation, 8 per cent of hemorrhage. Chronic ulcers are not infrequently followed by carcinoma of stomach and a large number die of tuberculosis.

The most frequent seat of gastric ulcer is upon the posterior wall along the pyloric half of the lesser curvature; a large number occur in the posterior wall of the body of the stomach, about 25 per cent in the pyloric portion and in the pyloris, 15 per cent in the lesser curvature of the stomach. About one ulcer in twenty occurs upon the anterior wall, yet perforation takes place more frequently here than elsewhere. Perforation of gastric ulcer may occur suddenly or gradually with results which are modified according to the anatomical site of the ulcer. Sudden perforation into the general peritoneal cavity with the escape of a large quantity of stomach contents produces peritoneal sepsis or diffuse peritonitis. The fatal accident is more likely to occur when the perforation takes place through the anterior wall of the stomach.

Hemorrhage occurs in a certain per cent of gastric ulcer cases. Moynihan's classification of hemorrhage from gastric ulcer divides them into four groups:

First—The hemorrhage is so small in amount as to escape observation with repeated microscopic and microchemical examinations of the stomach contents and feces.

Second—Repeated hemorrhages occur at irregular intervals, usually of several months, the amount of blood loss being considerable at each period. The patients have marked disturbances of gastric digestion and they become anemic.

Third — Hemorrhages considerable in amount and frequently repeated, occur in an individual who has long suffered from gastric disturbances.

Fourth — Bleeding occurs from one of the main arterial trunks of the stomach or other large vessel eroded during the process of the ulcer, such bleeding is sudden, continuous and uniformly fatal.

Cases of chronic ulcer without hemorrhage, in which the symptoms are those of chronic dyspepsia, accompanied by motor insufficiency of the stomach due to pyloric spasm or to actual narrowing of the pyloric orifice by cicatrical contraction or thickening and by a dilated stomach, are many in number.

A large ulcer in the body of the stomach may cause hour-glass contraction. One of the most valuable points of diagnosis is the history of the patient, such as attacks of digestive disturbances, extending over a period of years as a rule, and accompanied by excessive acid, pain, hemorrhage and, in the later stages, interference with the progress of food.

Acidity: At some time in the history of all ulcers the gastric secretions show an excess of hydrochloric acid. The finding of free hydrochloric acid in a fasting stomach and a few leukocytes often partially digested, are of great diagnostic value. Pain is the most common symptom of ulcer.

The differential diagnosis between ulcer of the stomach and duodenum can usually be made, the location of the pain to the right of the median line, the food distress coming on several hours after a meal are the important symptoms of duodenal ulcer. Microscopical examination of the food contents and the Roentgen ray are among the best means of diagnosis of gastric ulcer. In a certain per cent of chronic ulcer cases a tumefaction may be present without any malignancy.

Mr. Herbert Patterson, of London, is one of the noted gastric surgeons who does not agree as to the possibility of grafting malignant disease in simple ulcer of the stomach, while William J. Mayo, Moynihan, Wilson and others are of the opinion that gastric cancer can originate from gastric ulcer, Mayo stating that 71 per cent of cancers of the stomach have their origin

in simple ulcers. Futterer pointed out the relation of fishhook ulcer to gastric carcinoma and presented proof. Wilson and McCarty from the study of a large number of specimens showed that it was not the base but the overhanging margin of the ulcer that became carcinomatous.

Von Eiselsberg, of Vienna, has shown from the history of patients operated on in his clinic for gastric ulcer that 10 per cent have since died of cancer of the stomach, and later statistics of Von Eiselberg's clinic show that out of forty-one deaths following operation for gastric ulcer, 32 per cent were from gastric cancer. Recent data from other clinics show the same results.

Wilson has contributed to the theory that detached fragments of functionating gastric epithelium buried in the ulcer by scar tissue may have something to do with the starting point of cancer.

While all carcinomas of the stomach may not have their origin in ulcer, there is sufficient evidence to show that a preceding lesion in the gastric mucosa is nearly always present before carcinoma develops.

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American Veronal.

In the Trading with the Enemy Act recently passed by Congress, provision was made for the licensing of American manufacturers by the Federal Trade Commission to produce articles and substances patented in this country by enemy aliens. Already a number of chemical manufacturers have taken advantage of this provision, among them The Abbott Laboratories of Chicago, which has applied for and secured a license for the manufacture of Veronal, which, however, will be known hereafter by the name Barbital. This is the official name given it by the Federal Trade Commission, and this name must be used as the principal title by every firm manufacturing it under license from our Government.

The Abbott Laboratories have already begun the manufacture of Barbital (formerly known as Veronal), and we understand that in a short time it expects to have an abundant supply of this well known hypnotic, and that it will be made generally available through the trade. The quality of the product is guaranteed. Indeed, before a license is granted for the manufacture of any of these patented synthetics in the United States, the product must be submitted to rigid investigation at the hands of a chemist designated by the Federal Trade Commission. In this way Americans are assured of supplies of the American-made products at reasonable prices, and the manufacture of fine American chemicals is given the stimulus which it requires.

Those interested are urged to communicate with the Abbott Laboratories, Chicago.

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Beware of Swindlers.

No doubt you may have seen the several notices, under "General News" in the Journal A. M. A. in several recent issues, entitled "Once more a warning." These refer to swindlers operating in different sections of the country—various letters having been received from victims in Ohio, Colorado and other widely separated states. Now comes a letter from the well-known publishing house of W. B. Saunders Co., of Philadelphia, saying a man under the name of E. T. Rogers, claiming to represent the University Progressive Club of Cincinnati, for medical and other journals, has been victimizing physicians in Illinois; and the same subscription swindlers, or another under the name of Robert Wayne, has been relieving physicians of their well earned cash in the region of Gary, Indiana. It is believed there is concerted action, perhaps by an organized band, being taken at this time of the year, to victimize physicians on so-called "subscription" schemes. Every physician should decline to pay any money by check, or otherwise, to subscription agents not personally known to them, or for whom other physicians can not vouch. Many of these so-called agents operate under the guise of students "working their way through college."

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Dues of Members in the Army Service Will Be Paid.

At the January meeting of the Council it was decided to appropriate the necessary funds to pay the annual dues of all members of the Society who are in active service with the army or navy. Secretaries of county societies, in making their returns to the secretary of the State Society, should include the names of all those in good standing in 1917 that are now in actual service, and should designate these names as of members in the service.

This does not apply to county society dues, but it is presumed that each society will be willing to suspend its dues for these men during the war.

Lecture Bureau Discontinued.

The Council, at its January meeting, also decided that the Lecture Bureau should be discontinued. The amount appropriated for the expenses of lecturers was exhausted and the benefits that were expected to be derived from the plan did not materialize. There has been no lack of demand for the services of the Bureau—in fact it has been difficult to supply lecturers for all the dates requested. The purpose behind the plan was to build up the weaker organizations and put them upon a good working foundation. It was hoped that a few meetings, with some of the well known men in the profession on the program, would increase the local interest in society work and increase the membership. The requests for lectures came very largely from the societies that were well organized and in good working condition. Most any of the men who have supplied lectures for the Bureau would very willingly respond to invitations from any of these societies and it seemed unnecessary that the State Society should carry the burden of expense.

The Council decided that the matter of supplying lecturers should be left with the Councillor of each district. If in his judgment a society organization may be improved by such help he is empowered to engage a lecturer for some meeting of that county and charge the expense to the State Society.

"Where the Offense Is, Let the Great Axe Fall."

By this time everyone will have read the stories of the mistreatment of sick soldiers in some of the cantonments that were made public by Senator Chamberlain. By this time everyone will also have read the reports of the courtmartial of two officers of the medical corps for neglect of duty. There will arise in many minds a question if these men are being made the goats in a very serious condition of affairs, for which the medical department, if at all, is not alone responsible.

If there are officers, of whatever rank, in the medical corps of the army, whose professional viewpoints have been camouflaged by their uniforms and shoulder ornaments, who forget their duty to the sick and injured in their disciplinary training as officers, who forget that their duty in this war is the same duty to suffering mankind that they assumed when they became members of the medical profession, such officers should not only be dismissed from the army, but should be deprived of their standing in the profession and of their right to practice among civilized people. But we are not ready to

admit, on any of the evidence so far made public, that there are any such.

There are few men in the medical profession who will accept any but the most positive and conclusive evidence on such charges as were made against these officers. There seems to be an impression that to be tried by courtmartial is to be convicted. Perhaps this is because only the cases of those who are convicted are made public; or, perhaps, it is because such a trial is only given when the evidence is conclusive. In the cases of the two officers mentioned there seemed, at least, no doubt in the minds of the court, nor in the mind of the Judge Advocate General who recommended that a prison sentence be added to that of dismissal. Nor does there seem to be any doubt in the mind of the Secretary of War, who said: "The department sets its face against that sort of callous disregard of soldiers' health. I want doctors and the country to know that their lives and the welfare are a responsibility which I will not permit to be dodged by handling in a cavalier fashion." There are men who are not quite so certain of the guilt of at least one of the officers who was tried and convicted by courtmartial. We quote the following from a letter, written by a man, not an officer, who had an opportunity to examine the transcript and to gain some facts which the newspapers have not made public:

"Dr. Dwyer was tried by court-martial November 27, for neglect of duty. He was charged with failing to examine Private Christie L. Gherring, who was reported on sick report the morning of October 17. The facts are, as shown by the transcript of the records of the court-martial, that Gherring reported for sick call on the morning of October 17. Lieut. Dwyer was in charge of the infirmary. Gherring was examined by two doctors who were assistants to Dr. Dwyer, and they reported that he was not sick and that they thought he was shamming. He was marked "duty" on the sick book by Dr. Dwyer. He went back to his barracks and was returned to the infirmary on the afternoon of the 18th, on a cot, when a diagnosis of pneumonia was made and he was sent to the base hospital, where he died three days later.

"Lieut. Dwyer was charged with neglect of duty because he failed to recognize and treat a case of pneumonia on the morning of October 17, which was the first morning Gherring reported at the infirmary. There is no evidence to show that Gherring had pneumonia at this time. The two doctors who examined him that morning said that he was not sick. His only complaint was that he felt weak in the knees. He had no temperature and his pulse was not accelerated.

"At this time the surgeons in Camp Funston were staying on duty night and day. It was no uncommon thing for them to not get through their work until three or four o'clock in the morning. On the morning of October 17, Infirmary No. 4 had 390 men on sick report, and on that day the doctors of that infirmary did over 700 inoculations, a fact which should be taken into consideration. The surgeons had been ordered by the brigade commander to be on the lookout for malingering, which was quite common among the men in the camp at that time, and no doubt influenced the doctors who examined Gherring, as they both say they thought he was shamming. And it is a fact that a man may be well, but shamming, on Tuesday, have pneumonia on Wednesday and die on Sunday, and no one be responsible for his death.

"Furthermore, the man who made the charges and fomented them was an undoubted degenerate and, in my opinion, was at this time insane. He later turned bandit, bank robber—robbed the bank in Camp Funston, murdered four men in the bank and afterward committed suicide—Capt. Lewis Whisler. The testimony of this man should certainly not be considered, and neither should the testimony of his sergeants be given any weight, as they were under his influence so completely, and in fear of their insane captain."

A slightly different version of this unfortunate case appears in a news item from Wichita, under date of January 30, published in the Kansas City Times, January 31, and is as follows:

"A local physician at Camp Funston is authority for the statement that Capt. Lewis J. Whisler, who robbed the Camp Funston Bank, killed four men, wounded another and then committed suicide January 12, was the cause of the court-martial and dismissal of Lieut. James G. Dwyer

on charges of mistreatment of a sick soldier who failed to properly salute him. According to the Wichita physician, Whisler altered a sick book after he had miscarried Lieut. Dwyer's orders regarding the sick soldier, who was ordered to the hospital by Dwyer. Whisler compelled the soldier to mop camp after he was too weak to stand and he fainted. When Dwyer visited the place the soldier couldn't get up. Whisler, the Wichita man says, was the chief witness against Dwyer, who maintained in court-martial that he was not guilty as charged."

The other case was that of Lieut. Chas. W. Cole, of Norton, Kansas, who was on duty at Camp Beauregard. In this case the evidence at the courtmartial showed that several sick soldiers had been transferred from regimental infirmaries to base hospitals, and that no immediate attention had been paid to them. They were not admitted but were kept in the ambulance. Afterward Lieut. Cole went out to see them and refused to receive them into the base hospital, ordering them returned to the infirmaries. Those who know Dr. Cole will not readily accept these bare statements as complete evidence in the case. They know that if he did not immediately give his attention to these sick men, it was because he was too busily engaged with other sick men, or some other equally good reason; and if he refused to receive them it was because there was no room in the hospital for them, or an equally good reason. Men, like Dr. Cole, who have practiced medicine for several years in Kansas, are not the kind of men to neglect the sick.

It would seem from current reports that the hospitals have been greatly overcrowded, and hospital attendants have not been supplied in sufficient number, or with sufficient training, to meet the requirements, and that the medical officers have been seriously overworked.

If these are facts, they are facts which the Secretary of War apparently did not know, but it is not to be expected that one who has such vast responsibilities should be able to keep in touch with the details of every camp. But there must be some one, higher in authority than a lieutenant in the medical corps, upon whom the responsibility for the conditions complained of does lie. Those who have read the letter of the father of the boy who died from meningitis will recall the statement that the boy was dirty, and that the attendant said they were allowed but one change of bed clothing each week. A boy, confined in one of the hospitals with measles, wrote to his parents that there were sixty patients in his ward and one ward master to care for them. Some of these patients had pneumonia and some of them died. The ward master was an enlisted man with no training for the duty he was detailed to perform. A nurse at the same camp wrote to a friend that she had charge of from forty-five to sixty cases and had an untrained ward master to assist her. A nurse at another base hospital wrote to another nurse that she had been working from eighteen to twenty hours a day, that she had had to take care of fifteen cases of pneumonia and that ten of them died.

What superlative loyalty the parents, the wives, the sweethearts of these boys have, who have known of these conditions for months yet made little if any complaint.

The dismissal, or imprisonment, of a few medical officers will not expiate the loss of life resulting from lack of hospital accommodations, lack of facilities for bathing and properly clothing these sick men, lack of trained attendants to care for their needs and lack of drug supplies for their treatment. Every medical man who is loyal to his country and loyal to his profession, whether in the army or out of it, will welcome the most searching investigation and the fixing of the blame where it belongs. It is to be hoped, however, that in any serious investigation that may be undertaken, for this time and for this purpose at least, the barriers of code will be let down and both officers and privates will be permitted to tell what they know without fear of reprimand or abatement of favor. Enlisted men, who are perfectly frank with their relatives and friends, are naturally cautious and conservative when

in harness with the reins of discipline in the hands of a martinet.

But in this army, which is made up of men from all walks of life, selected for their physical, their mental and their moral fitness, there is none but an arbitrary class distinction. In intelligence, in morality and in physical manhood, the enlisted men rank as high as the commissioned officers. Among these men are our future statesmen, our future governors, our future congressmen and senators, and our future presidents. The country is willing and able to give them the comforts of life. The medical profession is willing and able to give them the most efficient medical service that any army in any country in the world has ever had. An unprejudiced observer and conservative writer, Mary Roberts Rinehart, says of the medical corps, in her letter to Mr. Baker:

"Of cruelty and indifference, I have found nothing. On the contrary, I have found the medical staffs of the hospitals both efficient and humane. When it is remembered that the medical men of these national army hospitals are volunteers, who have cheerfully relinquished the results of years of labor to give their services to the country, that they are of the best we have, as all volunteers are, that they are willing to undergo deprivation and hardship, to take care of our boys, it is wrong that the country at large should so misjudge them.

"The best specialists of the country have placed themselves at the disposal of the army medical department, and ninety-nine out of a hundred men in the drafted army are receiving better care than they could afford, under the best circumstances, to receive at home."

The men who have volunteered their services in the medical department of the army are anxious to do their part in the war and they want to do it right. A persistently overworked man cannot be expected to be unerring in judgment. The most experienced and skillful physician cannot secure the best results without adequate facilities and competent nurses. No fault can be found with the medical organization of this army, it is a wonderful accomplishment. The trouble seems to be in its dependent relationship to other departments of the army. Congress may ultimately provide some relief for a situation in which the Surgeon General is permitted to recommend that hospital accommodations be increased, sewer systems established, and that men be not crowded in their tents, instead of having authority to see that such things are done. It may in time be so arranged that medical staffs are enabled to provide for their own requirements and have full control of their own accessories and activities.

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Increased Popularity of Electricity and Radium.

Both of these remedial agents have passed through the "novelty" stage and are now being used and endorsed by hundreds of medical men of unquestioned standing and ability. Electricity and radium already have an important place in modern medical practice. But, without doubt, much is yet to be learned about their value in therapy.

If these two modalities can do even a part of what is claimed for them, then physicians should qualify themselves by reading, investigation and installation of equipment to use them in their practice, when indicated. The physician's obligations to his clients, no less than his duty to himself, require this.

In addition to the many and varied uses for which physicians have found electricity of value in medical science, they are now employing it extensively for commercial purposes, such as electric vehicles, lighting and telephone systems for offices, homes, sanitariums, hospitals and public institutions.

Radium is coming into use more and more by physicians, particularly in sanitariums and hospitals. In many internal, as well as external, conditions, radium is recognized as an important therapeutic agent.

The editorial staff of this Journal—your Journal—is in full sympathy with this movement, and invites frequent contributions in the way of case reports, discussions, and other clinical notes for publica-

tion. It is also hoped that arrangements can be made for having at least one paper on each of these subjects for our next, as well as subsequent, annual state meetings.

The more progressive manufacturers, some of whom are listed below, have rendered valuable service to the profession by collecting clinical data and publishing it in the form of reprints for free distribution to interested physicians. The reprints are, of course, in addition to their regular catalog literature, and may be obtained for the asking.

Victor Electric Corporation, 236 South Robey Street, Chicago.

Frank S. Betz Co., Hammond, Ind.

Merry Optical Co., Merry Bldg., Kansas City, Mo.

Radium Chemical Co., Pittsburgh, Pa.

Campbell X-Ray Co., 612 East Ninth Street, Kansas City, Mo.

Hettinger Bros. Manufacturing Co., Tenth and Grand, Kansas City, Mo.

Physicians Supply Co., 1021 Grand Avenue, Kansas City, Mo.

O. H. Gerry Optical Co., Kansas City, Missouri.

Columbian Optical Co., Kansas City, Mo.

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Principal Causes of the Rejection at Camps of Men Passed by the Local Board Surgeons.

At one time there was a tendency to criticize the doctors on the examining boards for carelessness, it being claimed that a large per cent of those sent to camp were rejected by the army surgeons at camp. It is a great satisfaction therefore to find the exoneration of these men coming from an authoritative source. The following appeared in the Bulletin of January 11:

The Provost Marshal General, in his report on the operation of the selective-service act, says:

Rumors here and there in the public press stated that the camp surgeons had discovered, among the men accepted by the local boards, some with glass eyes, some with cork legs, and some with other obvious disqualifications. If such men were found, no disparagement is involved for the local-board surgeons; for it is safe to assert that such grossly defective persons came from the contingent of about 20,000 men who had never appeared before the local boards, but had been gathered up by the adjutants general and sent direct to the camps. There is no ground for supposing that the local-board surgeons were either incompetent or careless to that extent. The spirit of their practice was to make all intendments in favor of the Government; but nothing permits us to suppose that they would or did send to camp any men with cork legs or glass eyes.

PERCENTAGES OF REJECTIONS.

Doubtless the local boards varied extremely in the strictness of their examinations. But so also, it seems, did the camp surgeons. The table shows that the percentage of rejections at camp varied between 0.72 per cent and 11.87 per cent; and as the physical condition of the men from the different regions can not entirely account for this, it must be attributable in part to differences of strictness in the examinations by the camp surgeons.

But were the Surgeon General's rules for physical examination, as set forth in the directions to the local boards, stricter than necessary for securing efficient fighting men? On this point the civilian surgeons have expressed variant opinions. A large majority consider that the physical requirements are not too exacting. But a considerable number deem the requirements too strict in many respects, notably as to the weight-and-height relation, teeth, eyes, and feet, and contend that the regulations as strictly applied tend to exclude many capable and efficient men. For example, one board cited a case of exclusion for flat-foot of a man who had for many consecutive seasons endured the hardships of a guide's vocation in the Canadian forests; and the prevalence of flat-foot among sturdy negroes of the South was frequently commented on.

Was there any extensive attempt at deception of the local board surgeons by registrants called for examination?

FEW ATTEMPTS AT DECEPTION.

It is gratifying to report that falsification was attempted to only a slight and negligible extent. Here and there a board reports a locality as showing 50 per cent of attempted falsification; but these instances were sporadic, and represent only some local obliquity of morals.

Of the various grounds for rejection, which were the most common? It must be left to the future to study accurately the valuable mass of data now latent in the records. Time has sufficed only to examine a small group of the records of rejections; 10,000 men were represented, spread over eight camps. The specific source of defect showing the largest percentage was eyes; and the next largest, teeth.

The Training Camps.

Some of the men who have applied for commissions in the Medical Officers' Reserve Corps, and some of those who anticipate making application, are losing enthusiasm on account of certain reports that are said to have come from the training camps. One of these reports, now frequently heard, is to the effect that the men in the training camps spend all their time in company drills, and have no clinics or opportunity for instruction in the real medical work of the army. This may be a disappointment to many of the men, but if true should not be discouraging. If one may judge from the appearance of the men who have been through this training course, they have been greatly benefited by it. From the nature of our work as practitioners most of us get soft, some of us fat, all of us showing too early the little disturbances of function which come from too much worry and too little physical exercise. This period of training has made a remarkable change in such men. A glance at one of them shows that he has a vigorous and healthy appearance that he did not have before. His circulation is no longer sluggish, his respiration no longer shallow; his muscles now feel like iron and his appetite and digestion are irreproachable. His intellect is clearer, his resistance is increased and his endurance extended. In other words he has had a few months of the right kind of vacation for a professional man and during that time he has been specially fitted for the strenuous life and arduous duties he will be required to meet when he gets into the war zone.

Another report which has added somewhat to the uneasiness of the newly commissioned is that many of the men are assigned to duty as Sanitary Officers, in which capacity their knowledge of medicine is of little use, and in which the duties could be as well performed by any of the enlisted men. It is well to keep in mind the fact that this is all preparatory work being done here and, while we do not know it to be so, we can imagine that it is necessary to assign some of the medical officers to minor duties now in order that there may be a sufficient number for the work to be done "over there." It is safe to say that every man in the medical corps will have ample opportunity to prove his skill in medicine or surgery when our army gets into action.

Opposed to the Tax.

The following is a copy of a resolution unanimously adopted by the Council of the Ohio State Medical Association, at the regular quarterly meeting held in Columbus, Monday, January 7, 1918:

"Resolved by the Council of the Ohio State Medical Association, after a careful investigation of Section 209 of the War Revenue Law: That that provision is entirely unfair, and works a serious injustice to professional men, this injustice being more particularly marked in the case of physicians, who without exception have always done a large amount of charity work, and who in particular as the result of the war have had increased work with lessened incomes:

"That the tax is particularly obnoxious because it imposes a special burden upon men who earn their incomes, while it exempts from that burden owners of inherited wealth who earn nothing but are sim-

ply parasites;

"That we, therefore, call upon our representatives in Congress to use their utmost endeavors to secure a repeal of this unjust and onerous tax which, so far as we can learn, has not been imposed, or even contemplated, in any of the other countries engaged in the present war."

Hospital Is Well Supplied Now

The following item, dated Camp Doniphan, February 1, appeared in the Kansas City Times of February 2:

"The supplies at the base hospital have been coming in at such a rate that new men sent there will not have to take their own mess kits and blankets. An order was issued today by division headquarters that all the men needed to take was toilet articles."

Military Anti-Tuberculosis Program Perfected.

Plans for a complete program for the prevention of tuberculosis in the army have been perfected by the National Association for the Study and Prevention of Tuberculosis working in co-operation with the Surgeon General, the Y. M. C. A., and other agencies. This, it is predicted, will put the impending second draft on a better health basis than the first. The program will include not only a follow-up for every man discharged on account of tuberculosis, but a thorough-going health educational campaign among the soldiers.

Prior to the first draft the National Association began to outline a preventive campaign. Owing to the magnitude of the task and the many practical delays in perfecting and applying the details of this scheme, the results were not as encouraging as might be expected. This was due to the fact that the report of names of men rejected by the draft on account of tuberculosis was inadequate, the slowness of the machinery in getting under way, and the many difficulties in determining the status of the men.

Inasmuch as these enlisted or drafted men do not become accepted soldiers until after their probationary period lasting from three to six months in the various services, the Government assumes no responsibility for the after-care of those whose health breaks down during that period. Hence, this problem belongs to the civilian boards of health and the unofficial health organizations.

The National Association program falls into two main divisions: (*a*) follow-up work and (*b*) educational work. The first obstacle to the follow-up program was Section 11 of the Selective Service Regulations regarding the second draft which forbids giving a record of a man's condition to anyone except certain designated officials. The National Association officers, however, placed before the War Department the importance of this work and were influential in persuading them to open the records of rejected men to state and local boards of health throughout the country, through the United States Public Health Service and the Council of National Defense.

Inasmuch as the above section of the regulations does not apply to men dismissed from training camps after they have passed draft boards, the Association arranged with the Surgeon General and the division surgeons in camps to receive the names of all men thus dismissed. These lists are divided up by states and forwarded to state associations and state boards of health for follow-up work. Where men are referred to localities where there are not at present facilities for this follow-up work, the Association will use its good offices to promote the establishing of such facilities.

In the meantime, the Medical Department of the Army has perfected its machinery for weeding out these tuberculosis cases. Every man passed by the draft board after going into camp is examined by the regimental surgeon, re-examined by a tuberculosis board and then if suspected of tuberculosis, again examined by a tuberculosis expert. This follows a general policy mapped out and recommended by the National Association.

A large number of men have already been accepted into the service who were known to be tuberculous, many of them formerly inmates of tuberculosis sanitaria. Part of the Association's work has been to get in touch with every tuberculosis sanatorium and dispensary in the country and compile lists of all recent male inmates of draft age, giving the history of their cases and whether or not it was known if they were in the army at present. Hundreds of such names have already been received. This data is forwarded to the training camps, the men are located and the results are reported back to the sources of information.

Furthermore, the Association has sent a letter to all of its fifteen hundred local co-operating agencies giving the provisions of the second draft and urging that these agencies procure the names and addresses of all the men of military age in their section who are known to have tuberculosis; get in touch with these men and arm them with the necessary affidavits to prevent, if possible, their being passed by the draft board, and recommend to the local draft boards the names of the approved tuberculosis experts in their section.

The Association is also co-operating with the Surgeon General's office to aid the Government in providing sanatoria for those men who have been discharged from the service on account of tuberculosis after their probationary period has expired. All full-fledged soldiers and sailors returned from France or other stations will be cared for as near to their own homes as possible in sanatoria accommodations provided by the Government. The Government intends to utilize as far as possible existing institutions.

From the United States Marine Corps the National Association has secured each month a report of men rejected for tuberculosis from all its recruiting stations, and these men will receive the regular follow-up attention.

From the second or educational division of the program it is hoped to derive the greater ultimate good by the establishment of fundamental preventive measures among the well.

The National Association is interested in any kind of an educational campaign among the men in the various military camps that will tend to promote interest and information with regard to the control and prevention of communicable diseases, and toward the promotion of public and individual health in general. In the mobilization of such large numbers of men in various camps throughout the United States there have developed an unusual number of somewhat serious epidemics of colds, coughs, pneumonia, measles and various other respiratory and communicable diseases. That all of these diseases can be controlled by education and by the exercise of adequate public health measures has been clearly demonstrated in the civilian population throughout the United States. Most of these epidemics are spread through ignorance and carelessness. It is inevitable where large numbers of men from all walks of life and with all possible diseases and variations of physical habits are thrown together in somewhat uncomfortable and crowded living conditions, that there will be an immediate increase in the amount of sickness from communicable diseases. It must be obvious, however, to even the most superficial observer, that if these men can be taught to maintain a reasonable standard of personal hygiene and can be given a knowledge of the methods and principles of the control of communicable diseases a rapid diminution in the sickness rate will follow.

In co-operation with the Educational Committee of the National War Work Council of the Y. M. C. A., the National Association will furnish a number of stock lectures dealing with tuberculosis together with lantern slides to illustrate them. It will also arrange to put the educational secretaries of each of the camps in touch with public lecturers in and around their respective camps. The Association has requested the War Department to give careful consideration to the desirability of appointing one or more special officers de-

tailed to lecture on tuberculosis and allied health subjects in all of the army camps throughout the country.

The Association has prepared a special circular entitled "Red Blood," giving in brief and attractive form a message to the soldier relative to personal fitness, a health "Don't Card"; and a Public Health Manual may also be distributed, the latter being a text book of personal hygiene.

The Association will also arrange to distribute through the departmental executives of the Y. M. C. A. a number of special tuberculosis exhibits known popularly as "The Parcel Post Exhibit." In connection with these, moving picture films and lantern slides will be used.

The National Association Field Secretary, Dr. Pattison, is visiting the training camps and supervising this educational work.

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Mobilizing the Profession far War.

Until the entire medical profession of the United States, or at least those who are mentally and physically fit and within the age limit, are mobilized within the Medical Reserve Corps of the United States Army, not until then can we give to the Surgeon General that efficiency which he so badly needs in having a large body of medical officers upon whom to draw.

You may never be called, at the same time your joining the Medical Reserve Corps and placing your services at the command of your country, clearly indicates the patriotism which the medical profession, as a whole, should evince and which we must manifest if we are to win the war.

Every doctor must realize that success depends upon a carefully selected and thoroughly trained body of medical officers. By careful selection, we mean the placing of a medical officer in a position where he is best fitted for the service, and only by having an immense corps or the entire profession mobilized upon a war basis can we serve our country to the best possible advantage.

This mobilization of the entire profession should come from within the body itself, but every physician coming within the requirements of the service, as to age and physical fitness, should seriously consider this suggestion and not wait for complete mobilization but apply at once for a commission in the Medical Reserve Corps of the United States Army.

It is not only for the combatant forces that medical officers are required, but for sanitation, hospital camps, cantonments and in other departments where the health and life of the forces are dependent upon the medical officer.

We have within the profession a sufficient number of doctors to fully meet the requirements of the Surgeon General's office, whatever they might be, but to be of service, you must join the Medical Reserve Corps to enable you to meet the appeal which is now being made for a large and efficient Medical Reserve Corps upon which the Surgeon General may draw as requirements demand.

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Dr. E. H. Skinner, of Kansas City, Missouri, who has been conducting a school of instruction in Roentgenology for officers of the medical corps of the army, has recently been called into active service. Dr. O. W. Swope, who has recently been associated with him, will conduct his X-Ray laboratory during the absence of Dr. Skinner.

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According to an item appearing in the Kansas City papers the Grandview Sanitarium was seriously damaged by fire about the last of January. It was owned by Dr. S. S. Glasscock and was one of the largest and finest institutions of its kind in the West.

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News has been received of the death of Dr. Herbert Arnold Van Duyn, Hill City. Dr. Van Duyn was 46 years old, a graduate of the College of Physicians and Surgeons, Chicago, 1893. He was commissioned a Lieutenant in the M. O. R. C., September 28, 1917. He died at Hill City on January 28, 1918, and was buried at Middleport, Ohio.

According to reports received the Missouri Building in Kansas City, occupied by the Physicians Supply Co., has been completely destroyed by fire. The stock of instruments and supplied was very large.

SOCIETY NOTES.

FRANKLIN COUNTY SOCIETY.

The Franklin County Medical Society met at the office of Dr. J. B. Davis. The annual election of officers resulted as follows: President, Dr. S. D. E. Woods, Princeton, Kansas; vice president, Dr. H. B. Johnson, Pomona, Kansas; secretary, Dr. H. L. Kennedy, 322 South Main Street, Ottawa, Kansas. The annual banquet which has been held by the Franklin County Society each year was postponed this year on account of the war.

H. L. KENNEDY, M.D., Secretary.

PRATT COUNTY SOCIETY.

At our meeting of January 7, the following officers were elected: M. C. Jenkins, president, Pratt; G. E. Martin, vice president, Cullison; C. H. Fain, secretary, Pratt.

G. W. Maness, of Preston, joined our Society and also has received a commission in the Reserve Corps.

Dr. C. E. Phillips, of Zenda, Kansas, has moved to Pratt and transferred his membership from Kingman County to Pratt County.

M. C. JENKINS.

DOUGLAS COUNTY SOCIETY.

The Douglas County Medical Society met in regular session in the Chamber of Commerce rooms in Lawrence, on January 8. The following officers were duly elected for the ensuing year: Dr. Geo. M. Liston, of Baldwin, president; Dr. C. E. Orelup, of Lawrence, vice president; Dr. W. C. McConnell, of Lawrence, secretary; Dr. E. M. Owen, of Lawrence, treasurer; Dr. J. B. Henry, of Lawrence, censor.

The Douglas County Society is in the best working order that it has been for some years, which condition is largely due to the efficient work of the retiring president, Dr. E. J. Blair, who made a rousing speech in response to a vote of thanks by the Society.

W. C. MCCONNELL, Secretary.

ALLEN COUNTY SOCIETY.

At the December meeting of the Allen County Medical Society Dr. R. O. Christion of Iola was elected president, Dr. W. R. Heylmun was elected vice president, Dr. J. G. Walker was elected secretary, Dr. A. J. Fulton, treasurer, and Dr. P. S. Mitchell for delegate.

J. G. WALKER, Secretary.

BOURBON COUNTY SOCIETY.

At the December meeting of the Barton County Medical Society, officers for 1918 were elected as follows: President, H. C. Embry, Hoisington; vice president, A. H. Connett, Great Bend; secretary and treasurer, T. J. Brown, Hoisington; censors, E. E. Morrison and A. Kendall, Great Bend; delegates to state convention, M. F. Russell and E. C. Button, Great Bend.

T. J. BROWN, M.D., Secretary.

MISCELLANEOUS

The so-called fractional method of gastric analysis advocated by Rehfuss has been found to have such advantages that it has been introduced in the Battle Creek Sanitarium, where test meals to the number of thousands were given each year. To the patients, the new plan is vastly preferable. Indeed, the swallowing of what was often called "the garden hose" was attended in most cases by actual suffering and in many by severe pain. Under the fractional method, a very small tube is used. An oval tip, made of metal and perforated, makes the swallowing easy. Of course it is inconvenient to have to sit for an hour and a half or two hours without removing the tube, but there is no real distress. The usual test meal of two slices of toast and a glass of water is given, at intervals of half an hour, a small specimen of the gastric juice, ten or sixteen c.c., is taken,

until the acidity curve begins definitely to come down.

Under the old method the practice was to take out all the gastric juice at the end of an hour. At Battle Creek the period has been lengthened to an hour and a quarter because this was found to be the usual time of greatest acidity. A comparison of the two methods shows that the original plan was misleading in many instances. Under that procedure, cases would be set down as normal if the acidity was shown to be at the usual percentage one hour after the meal. However, as the fractional method proves, many patients who have the right acidity at that minute may have far too little or too much before and after the hour has passed. By studying the complete cycle of digestion an accurate diagnosis may be made.

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Scope of Medical Training Being Extended at Camps

Extensions are being made to the scope of the medical training camps at Fort Oglethorpe, Ga., and Fort Riley, Kansas, by the addition of courses in specialties required of the Medical, Sanitary, and Veterinary Corps under Surg. Gen, Gorgas. There are at present 5,400 officers and men under training at Fort Oglethorpe and 3,800 at Fort Riley. Fort Riley has a capacity of 7,000. Enlargement of the school at Fort Oglethorpe to the same capacity has been authorized, its present capacity being 5,500. The ultimate needs of the Medical Department of the Army look to training camps of capacities totaling 35,000 to 40,000 officers and men.

NEARLY THIRTY THOUSAND GRADUATES.

There have been graduated from medical training camps since June 1, or are now under instruction, a total of about 9,000 officers and about 20,000 enlisted men since June 1. Until December 1 the medical training camp at Fort Benjamin Harrison, Indiana, and the one at Fort Des Moines, Iowa, for colored officers and men, had been contributing to the total, but these camps have been discontinued.

Ten new sections have recently been or are now being established for officers in the medical training camps. These are for the following:

(1) X-ray specialists; (2) orthopedic surgeons; (3) psychologists; (4) special examining surgeons; (5) sanitary engineers; (6) veterinarians; (7) sanitarians; (8) hospital administration; (9) laboratory specialists (being established); (10) dental surgeons (being established).

THREE ADDITIONAL COURSES.

Consideration is being given to plans for the establishment of three additional courses, one in general military surgery, one for genito-urinary surgery, and one for military surgery of the brain, head, and face.

Various special groups now in active service have been trained since the opening of the schools. These include officers and men to operate ambulance companies, field hospitals, evacuation hospitals, base hospitals, hospital trains, etc. — Bulletin, January 22.

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Bulletin on Meningitis.

At this season of the year, when cerebrospinal fever prevails, and there are more or less outbreaks of this dreaded disease throughout the United States, a bulletin on the diagnosis and treatment, which has been recently published by the Mulford Company, a copy of which is being forwarded to you, will no doubt be of much interest. Our text-books and other books of reference are not complete, and this brochure will be found to embrace information secured from hospitals, both military and naval, boards of health and information generally obtained from the entire world.

The comprehensive information on symptoms, diagnosis, treatment, carriers and culture, should prove of the greatest value to every physician, and especially those who are associated with and have care of army and navy camps and cantonments, as the occurrence of spinal meningitis is of more or less frequency, and is found to be most difficult to control.

Reporting of Accidents from Local Anesthetics.

To the Editor: The Committee on Therapeutic Research of the Council of Pharmacy and Chemistry of the American Medical Association has undertaken a study of the accidents following the clinical use of local anesthetics, especially those following ordinary therapeutic doses. It is hoped that this study may lead to a better understanding of the cause of such accidents, and consequently to methods of avoiding them, or, at least, of treating them successfully when they occur.

It is becoming apparent that several of the local anesthetics, if not all of those in general use, are prone to cause death or symptoms of severe poisoning in a small percentage of those cases in which the dose used has been hitherto considered quite safe.

The infrequent occurrence of these accidents and their production by relatively small doses point to a peculiar hypersensitiveness on the part of those in whom the accidents occur. The data necessary for a study of these accidents are at present wholly insufficient, especially since the symptoms described in most of the cases are quite different from those commonly observed in animals even after the administration of toxic, but not fatal, doses.

Such accidents are seldom reported in detail in the medical literature, partly because physicians and dentists fear that they may be held to blame should they report them; partly, perhaps, because they have failed to appreciate the importance of the matter from the standpoint of the protection of the public.

It is evident that a broader view should prevail, and that physicians should be informed regarding the conditions under which such accidents occur in order that they may be avoided. It is also evident that the best protection against such unjust accusations, and the best means of preventing such accidents consist in the publication of careful detailed records when they have occurred, with the attending circumstances. These should be reported in the medical or dental journals when possible; but when, for any reason, this seems undesirable, a confidential report may be filed with Dr. R. A. Hatcher, 414 East Twenty-sixth Street, New York City, who has been appointed by the committee to collect this information.

If desired, such reports will be considered strictly confidential so far as the name of the patient and that of the medical attendant are concerned and such information will be used solely as a means of studying the problem of toxicity of this class of agents, unless permission is given to use the name.

All available facts, both public and private, should be included in these reports, but the following data are especially to be desired in those cases in which more detailed reports cannot be made:

The age, sex, and general history of the patient should be given in as great detail as possible. The state of the nervous system appears to be of especial importance. The dosage employed should be stated as accurately as possible; also the concentration of the solution employed, the site of the injection (whether intramuscular, perineural or strictly subcutaneous), and whether applied to the mouth, nose, or other part of the body. The possibility of an injection having been made into a small vein during intramuscular injection or into the gums should be considered. In such cases the action begins almost at once, that is, within a few seconds.

The previous condition of the heart and respiration should be reported if possible; and, of course, the effects of the drug on the heart and respiration, as well as the duration of the symptoms, should be recorded. If antidotes are employed, their nature and dosage should be stated, together with the character and time of appearance of the effects induced by the antidotes. It is important to state whether antidotes were administered orally, or by subcutaneous, intramuscular or intravenous injection, and the concentration in which such antidotes were used.

While such detailed information, to-

gether with any other available data, are desirable, it is not to be understood that the inability to supply such details should prevent the publication of reports of poisoning, however meager the data, so long as accuracy is observed.

The committee urges on all anesthetists, surgeons, physicians and dentists the making of such reports as a public duty; it asks that they read this appeal with especial attention of the character of observations desired.

TORALD SOLLMANN, Chairman
R. A. HATCHER, Special Referee
Therapeutic Research Committee of the Council on Pharmacy and Chemistry of the American Medical Association.

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Saving the Children.

The lives of one hundred thousand of the nation's children are to be saved in a child welfare drive which the Federal Children's Bureau has announced today. The drive will begin on April 6, one year from the day the United States declared war, and the first day of the Children's Year.

Public health authorities agree that half the deaths of young children are easily preventable. Each state will be assigned a definite quota of the hundred thousand lives to save. State councils of defense and the state women's committees are being called upon to be responsible for the state quotas.

Methods of work will be those which have already been proved efficient in saving children's lives in the United States and other warring countries.

To inaugurate the Children's Year a nation-wide weighing and measuring of babies and children of pre-school age will be made. No such general test of the well-being of children has ever been attempted. It will show each community what its children need if the men of the rising generation are to be free from the physical defects which the draft has revealed.

The plans contemplate economy for every purpose except for the essential means of protecting child life.

Rest in the Treatment of Tuberculosis.

J. H. Pratt, of Boston, in a paper read before the American Medical Association, June, 1917, published in the American Review of Tuberculosis for January, reviews the history of the rest treatment of tuberculosis, describes his own application of this treatment and compares his results with those of others. Brehmer was one of the first men to treat consumption successfully and while he is known as the advocate of exercise as a means of cure his treatment was in reality a modified rest treatment in which the patients were most carefully guarded against overexertion. His patient and assistant Dettweiler used reclining chairs in the open air for prolonged periods and attributed his success to the open air rather than to the rest of lungs and body. He recognized the fact that "absolute rest" was the most valuable treatment in combating the fever of phthisis. Trudeau, learning of the work of Brehmer and of Dettweiler through an English journal, began work along similar lines at Saranac, in 1885, and his experience made him a firm advocate of the rest treatment. Independently, Kretzschmar, of Brooklyn, published in 1888 an excellent account of the Dettweiler method of treatment and urged the erection near New York of a proper sanatorium for the introduction of this therapy. In Germany the importance of rest was even more fully recognized by Turban, Cornet and Penzoldt, but in this country the influence of Dettweiler was slight despite the work of Trudeau, Minor and a few others. The treatment generally advocated here was exercise in the open air on the theory that the tuberculosis was favorably influenced by the "auto-inoculation" induced by labor. Even the advocates of this treatment at the Brompton Hospital Sanatorium have been disappointed in the results. The studies of Barnes, of the Rhode Island Sanatorium, indicated that the mild febrile auto-inoculations were injurious. Nothing could indicate more clearly the failure to recognize the importance of rest by those in charge of the tuberculosis campaign

than a pamphlet of the New York State Department of Health, which states under "How to treat and cure tuberculosis": "It it well to rest for half an hour or if possible a little more, before and after each meal." Or the Red Cross test book on hygiene and home care of the sick in which the reader is told that "a dry climate and an outdoor life with abundant, nourishing food cover the special treatment" of tuberculosis.

Tendeloo ascribed the benefits of rest to the fact that with diminution of respiratory movements the lymph flow falls almost to zero, the nutrition of the affected area is shut off, tuberculous toxins and products of disintegrations accumulate in it until the growth of bacilli and production of toxin ceases. Rubel showed in rabbits that after intravenous injections the tuberculous process was more benign and chronic in the lung kept at comparative rest than in the freely moving lung. Krause has stressed the importance of mechanical walling off of foci by scar tissue. Injury from exercise cannot always be detected with the most careful supervision until it is too late to prevent renewed activity. On this basis the more complete the rest the shorter will be the duration of treatment and the greater the probability of recovery. According to Pratt there should be complete physical and mental rest in bed out of doors, in the recumbent or semi-recumbent position with as complete elimination as possible of all activity or excitement. The duration of this period depends more upon the severity or extent of the disease in the lungs at the time the treatment is begun than on the extent and rapidity of the improvement during the first weeks of treatment. Unnecessary delay in starting exercise will do no positive harm. Patients with fever should be given typhoid rest treatment. It may be necessary to eliminate every motion except the handling of the sputum box. Exercise should not be begun until several weeks after the temperature has reached normal, as shown by the two hourly temperatures between 8 a.m. and 8 p.m. on several successive days. When exercise is begun the allotted amount should be taken every other day, as recommended by Brown, to allow of more ready detection of injury from overexertion. Exercise is given not as treatment but to make the rest less dull, to encourage the patient and prepare him for a return to a normal life.

Objections to the rest treatment are easily met. Those that have been accused of overdoing the rest treatment are now more than ever insistent upon its advantages. Pratt himself has used more prolonged rest than any other writer and the result has been a larger percentage of recoveries. It is suggested that different patients need different treatment. It would be as logical to make similar distinctions among patients ill with typhoid fever or with pneumonia. The objection that rest may weaken the heart is purely theoretical and not borne out by facts. No industrious person may ever be converted by the rest treatment into a lazy loafer. The contention that the rest treatment makes patients nervous and depressed is not borne out by Pratt's experience.

Pratt compares the results of this rest treatment of the Emanuel Church tuberculosis class with those of the treatment with graduated exercise at the Brompton Hospital Sanatorium. The class consisted of unselected cases of whom 36 per cent were far advanced supervised by the class method. The average duration of bed rest was about four months and the duration of graduated exercise combined with bed rest four to seven months. For comparison of results those have been selected in which the wage earning power had been restored while under treatment the comparison shows that prolonged rest leads to permanent recovery in a large proportion of the cases treated and that strengthening a man's muscles and improving his general condition by graded work does not heal the tuberculosis process in the lungs. The comparison is in favor of the class despite the generally recognized difficulties of home treatment.

Pratt concludes that the failure to cure

pulmonary tuberculosis is not due to the incurability of the disease but to the fact that the proper treatment has not been employed. Tuberculosis can be cured in and out of sanatoria in a large proportion of cases by the strict rest treatment. As the most complete rest can only be obtained in bed it is evident that bed rest out of doors should yield a larger percentage of recoveries in a shorter period of time than any other known method.—Pratt, J. H.: The Importance of Long-Continued Rest in the Treatment of Pulmonary Tuberculosis, Am. Rev. Tub., January, 1918, I, 637.

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Measles and German Measles in the Army Camps.

While much is said regarding measles (morbilli) in the army camps, it seems to be less generally realized that German measles (rubeola) also is prevalent. Rubeola is practically never fatal and complications are rare, whereas measles is often accompanied by most serious complications (bronchopneumonia, otitis media), besides leaving the subject, if he recovers, strongly predisposed to tuberculosis. Many who have suffered from measles in the army camps also have suffered from bronchopneumonia due either to streptococci or pneumococci. A number have died, and for those that have recovered from the complicating pneumonia, convalescence has been in many instances delayed by an empyemic sequel. The differentiation of morbilli from rubeola, though difficult in single instances, is in the majority of cases a relatively easy matter to the closely observant physician. In measles, the prodromal stage with its catarrhal symptoms (coryza, photophobia, conjunctivitis and cough) is, in itself, fairly characteristic; and when the disease is epidemic, such catarrhal symptoms should at once excite suspicion. The preceding incubatory leukopenia with relative lymphocytosis and eosinopenia is of some diagnostic importance. Above all, the pathognomonic "Koplik's spots," small, slightly elevated, white or bluish white, sharply circumscribed white spots, the size of the head of a pin or smaller, surrounded by a narrow hyperemic zone, should be sought for on the buccal mucous membrane —opposite the molar teeth, inside the lips, or at the junction of the gums with the cheeks. They are present in six out of every seven cases of morbilli, and are visible in the prodromal stage. Again, the maculopapular eruption of morbilli, once it has appeared, is very characteristic. It comes first on the face and scalp, often in front of and behind the ears, and extends to the neck, upper trunk and arms, and, later, to the lower trunk, buttocks and thighs, requiring from two to two and a half days after its first appearance for its full development. At first it is pink, but soon it turns darker red and often brownish red. As von Pirquet has shown, the times of appearance of the rash on the different parts of the body stand in definite relations to the cutaneous arterial supply; the rash appears earliest on parts of the skin in which the arterial distance from the heart is least and the circulation liveliest. The crescentic grouping of the maculopapular eruption is often striking. In rubeola, or German measles, the prodromes are mild or absent, Koplik's spots are not present, the rash is macular rather than papular, it is of a lighter rose red, and its macules are rarely confluent. Beginning on the face or scalp, it extends (in crops) over the rest of the body in about twenty-four hours. In a few instances, the rash resembles that of measles; more often it could be confused with that of scalret fever.—Jour. A. M. A., Feb. 2, 1918.

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Psychopathic Hospitals.

After mentioning the stigma popularly attached to insanity, Richard Dewey, Wauwatosa, Wis. (Journal A. M. A., Feb. 2, 1918), advocates a law placing the patient within the walls of the primary detentional or psychopathic hospital and putting in operation through the action of the court itself or at regular stated intervals a method of inquiry personally addressed to each patient which will give him the op-

portunity of saying whether he remains in the hospital of his own free will or wishes his liberty. Dewey believes that by this method all cases really requiring legal assistance would naturally come to light, and in most of them it would be found that there would be no occasion for court inquiry. He believes that in all communities a psychopathic or detention hospital should be utilized and patients admitted in the same manner as those admitted to other hospitals, and freely discharged as well, except in cases when they are in a condi- and for others that they should be at tion in which it is unsafe for themselves large. They should be free to go and come, if they are capable of doing so. No so-called ban or stigma should be placed on them, on account of mental illness, any more than on account of physical illness.

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Lung Abscess.

W. D. Tewksbury, Washington, D. C. (Journal A. M. A., Feb. 2, 1918), refers to a former paper in the Journal in which he described a case treated by artificial pneumothorax, which he considered a new method at the time, and states that he has received a large number of letters from physicians treating abscess of the lung. In Washington alone during the past year he has seen fifteen cases following operations on the nose and throat. Hence he thinks the condition is less infrequent than has been supposed. In the present article he aims to consider only cases following operation on the nose and throat. The infection is of the usual mixed type with the staphylococcus and the streptococcus predominating. There are two theories as to the mode of infection: first, that the infecting organisms are carried into the lung by the direct aspiration of infected blood during the anesthesia, and second, that they are carried by infected clots with a resulting septic infarct. The symptoms appear from four to ten days after operation and begin with a rise of temperature, dry cough, pain in the chest on the af-

(Continued on Page xv)

Various incomes are reported but the changes in the amount of milk purchased are not unlike in the different earnings groups. Some mothers seem to realize that milk must be provided for their children at whatever sacrifice; others who can better afford to buy milk do not understand its importance and let their children go without it. The foreign born mothers, although their incomes are slightly lower than the incomes of the native white mothers, have more generally than any other group continued to buy milk. Almost half of the foreign born mothers have either continued the amount purchased last year or increased it, and only one in ten of the foreign mothers (as against one in three of the other mothers) are now buying no milk at all.

The Children's Bureau states: "Taking a pint and a half of fresh milk as the desirable daily allowance for the average child, those 756 children were having last year on an average daily only 40 per cent of what they should have had; this year their daily average has dwindled to 14.4 per cent of this allowance.

"The work of Children's Year should emphasize in every community the importance of fresh milk in the diet of young children. Without proper nourishment children can not keep well and free from physical defects, and a campaign of education on the feeding of children is an essential part of the saving of 100,000 lives during the second year of the war."

Conversion of Liberty Bonds.

Liberty Bonds of the first issue, Liberty Bonds of the second issue, and Liberty Bonds obtained by converting bonds of the first issue into bonds of the second issue can be converted into bonds of the third issue during the six months' period beginning May 9 and ending November 9, 1918.

Delivery of the bonds issued in conversion can not be made prior to July 1, but bonds presented for conversion on or before that date will be retained by the Treasury and a nonnegotiable receipt issued therefor. Interest will be adjusted

in each case between the Government and the bondholder.

After November 9, 1918, no further rights of conversion will attach to the 4 per cent bonds, either the original bonds of the second loan or those obtained by conversion of bonds of the first loan. Bonds of the first issue, however, will still have the privilege of conversion into any bonds issued, at a higher rate of interest than 3½ per cent, before the termination of the war. All of the 4½ per cent bonds are nonconvertible.

Bonds for conversion may be surrendered at any Federal Reserve Bank or at the Treasury Department. Registered bonds must be assigned to the Secretary of the Treasury, but such assignment need not be witnessed.

On conversion of registered bonds, registered bonds only will be delivered, neither change of ownership nor change into coupon bonds being permitted.

Coupon bonds, however, may be converted into registered bonds upon request. Coupon bonds must have the May 15, or June 15, 1918, coupons and all subsequent coupons attached. Coupon bonds issued from conversion will have only four interest coupons attached, and later must be exchanged for new bonds with the full number of coupons attached.

All bonds issued upon conversion into 4½ per cent bonds will be dated May 9. The bonds secured upon conversion of bonds of the first loan and bonds obtained by conversion of bonds of the first loan into 4 per cent bonds must carry interest from June 15. Bonds issued upon conversion of 4 per cent bonds of the second issue will carry interest from May 15.

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Furnishing a Substitute.

Bessie had a new dime to invest in ice cream soda.

"Why don't you give your dime to missions?" said the minister who was calling.

"I thought about that," said Bessie, "but I think I'll buy the ice cream and let the druggist give it to the missions."—Christian Herald.

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The Enlarging Scope of Neurological Surgery.

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Read at the Fifty-second Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

In 1885 Victor Horsley removed the first brain tumor successfully and in 1887 the first spinal tumor. This was almost eighty years after McDowell did his first ovariotomy.

Neurological surgery may be said to have started with those two successful cases, but the subject has but slowly gained the recognition it deserves. This may be accounted for in several ways. First of all, the profession generally does not realize that there are quite a number of neurological conditions which can be effectively trained by surgical measures. Secondly, the lack of neurological training and consequently the lack of interest in these conditions.

Neurological surgery to most medical men means operations for brain tumor and that, as a rule, they think, spells disaster. It is true that the results of brain tumor operations are not as satisfactory as they will be when we get these cases earlier, that is, when in the operable stage, but the results are already better than they were five years ago.

This feeling about the seriousness and danger of operations for brain tumor has been applied indiscriminately to every cranial operation, which is most unfortunate, for it keeps physicians from advising operation to patients who might readily be relieved and at comparatively small risk. Some years ago I reviewed our cases and found that in a consecutive series of sixty-four cranial operations, we had had six deaths, a mortality of 9.3 per cent. These figures need to be improved but certainly are by no means discouraging. Ninety-six cases with brain tumors, 20 per cent mortality.

What types of conditions, then, lend themselves to operation and may be cured or relieved by surgical intervention?

Quite a large group even after all cases unsuitable for operation have been eliminated is made up of epilepsies. I am drawing the line sharper and sharper each year as to which epilepsies should be operated. Unless the convulsions present a definite focal character, I leave them alone, but it is well to remember that the patient whose general convulsion is initiated by a definite sensory aura, a sensation of smell, taste, vision, or hearing, has just as much of a focal or Jacksonian convulsion as the patient whose thumb twitches characteristically for half an hour before his general convulsion begins. In other words, many epilepsies are called general that on careful study really prove to be focal. Some of these cases have traumatic cysts following old injuries; not a few have a more diffuse process that I usually speak of as a subarachnoid cyst; some have the remains of an old chronic meningitis; an occasional one (two in my experience) have a congenital nævus. One of these had been having twenty to thirty

Jacksonian attacks a day and since the operation some three years ago has had none.

What are the results in these cases? Of twenty-three cases which occurred in the course of several years, we lost none.

The next question is, are they all relieved of their symptoms? No, not all, but a good many have no more convulsions at all. What sort of an operative procedure is required to relieve these conditions? Sometimes a mere evacuation of the cyst suffices; at other times the entire cortex which is diseased must be excised, but unless absolutely necessary, I do not resort to this latter procedure, as it means, if the excised portion is in the motor area, that the patient will have a paralyzed extremity. I have done such an excision only three or four times. Patients, however, are quite willing to have a paralyzed extremity rather than continue with their convulsions. Then, too, a patient after a cortical excision which has produced paralysis may regain considerable power in a few weeks so that he can use his extremity to some extent.

There is another group which is becoming more interesting as prospect of relief becomes more promising, namely, hydrocephalus.

The increase of our knowledge of this condition is an admirable example of how this field is growing. Until a very few years ago all cases of hydrocephalus were considered alike; now we are able to differentiate three types — the obstructive hydrocephalus, the secretory hydrocephalus, that is one in which there is an excessive secretion of cerebrospinal fluid, and a third, the absorptive type, in which the cerebrospinal fluid is not taken up in the circulation as rapidly as normally and consequently might be said to stagnate.

This differentiation is accomplished by the injection of a specially prepared phenolsulpho-phthalein into the ventricle, and normally it should appear in thirty seconds in the spinal fluid upon lumbar puncture. If it is delayed beyond a certain time, arbitrarily set at twenty minutes, there is an obstruction between the ventricle and spinal meninges and we are dealing with an obstructive hydrocephalus. On the other hand, if the dye appears promptly in the spinal fluid and also promptly in the urine, we have the secretory type, while if the phenol-phthalein appears promptly in the spinal canal, but slowly in the urine, the defect is one of absorption. Once having determined what kind of hydrocephalus we are dealing with, the treatment may be more intelligently undertaken.

In the first type, the obstruction can only occur at the foramen of Magendie and foramina of Luscka in the roof of the fourth ventricle or at the aqueduct of Sylvius. The making of a new foramen of Magendie is quite simple by an operation that I shall illustrate to you a little later. The relief of a number of cases indicates that this is a promising procedure. Obstruction of the aqueduct of Sylvius is a more difficult problem to deal with, but not insurmountable. This past year I have had a case of a tumor in this region in a child of eighteen months, which we removed, and this indicated that the procedure is possible. This child was operated some eight months ago and when we removed the tumor, cerebrospinal fluid escaped from the obstructed aqueduct of Sylvius.

The operative procedure used in these cases also creates a new area from which cerebrospinal fluid may be absorbed and therefore may be used in those cases of hydrocephalus in which absorption has been defective. This operation, it seems to me, is a more logical one than the many that have been devised in which channels for absorption of cerebrospinal fluid were created by foreign bodies, tubes, strands of catgut, linen thread, rubber tubes, etc., for the objection to all of these is that an irritative inflammation is set up which soon closes the newly created pathway.

The third type should be treated, I believe, as hypersecretion of other glands, notably the thyroid is treated, namely by partial excision of the choroid gland. That seems wild and impossible but in a hydro-

cephalic the ventricle is reached very easily and extirpation of the plexus would offer no great difficulty. Though I have not as yet had a suitable case on which to carry out this procedure, I have several times been in the lateral ventricle and know that it can be done, and furthermore, that patients, particularly hydrocephalics, stand opening of the ventricle well.

Occasionally, among the vast army of syphilitics we see cases with choked disc and rapidly failing vision. These do wonderfully well with a decompression promptly done; in fact, patients often respond to antisyphilitic measures better after a decompression has been done than before. This I believe may be due to the fact that the increased intracranial pressure interferes with the absorption of specific drugs but after the pressure has been relieved this goes on more readily.

A choked disc should always be a clear indication for operation, and a delay while prolonged specific treatment is tried often ends disastrously. Let me take this opportunity to emphasize that the fewest cases giving symptoms of intracranial pressure are due to syphilis. A cerebral gumma is very rare and *it* is a tumor and cannot be readily, if at all, removed by antisyphilitic treatment. It must be removed by operation.

Perhaps the most gratifying cases in the whole field of neurological surgery are the trigeminal neuralgias. If the second or third branch of the fifth nerve is involved, or both of these, I think it always well and wise to try deep injections of alcohol according to the method popularized by Patrick. The first branch of the fifth nerve I think should not be injected with alcohol on account of the danger of injuring the optic nerve, for to inject it the alcohol has to be put into the orbit. Those neuralgias that recur after alcohol injections or which have involvement of all three branches of the fifth nerve should be operated upon. I do not believe in the various peripheral operations, however, as they give temporary, often no relief at all. After having exhausted the alcohol injections the only operation is that on the Gasserian ganglion. This operation is generally considered very dangerous, very difficult, and having a high mortality. It is unquestionably a serious procedure, but when done carefully and deliberately, not dangerous. Our own series is small, some twenty-odd cases, but thus far we have not lost a patient, so that we feel justified in advising the operation. Does it always cure? Yes, always if properly done, and whenever there is a recurrence the operation has been imperfectly done; that is, all the fibers of the ganglion have not been removed.

A very large series of cases is that of skull fractures, and here I get to a subject with which many of you are very familiar and about which, perhaps, you have very strong views. It is a subject that has assumed enormous importance in the past years, since, in addition to the many skull fractures that occur in civil life, gunshot wounds of the head have become a grave problem in the case of our soldiers. Ten per cent of all wounds at the front are head wounds, so that with the huge number of men engaged you can appreciate what a terrific problem we are face to face with. The injuries sustained in war differ in one respect from those occurring in civil life, in that the former are almost all compound fractures so that the danger of infection is present. Infections of the brain and meninges are still problems that have not been satisfactorily solved and it is devoutly to be hoped that some very definite advance may be made along these lines before many of our boys get into the fighting. Certain points, however, will do much to give better results in these compound fractures. The literature based on war wounds draws attention constantly to the difference between a contaminated and an infected wound; that is, a wound that has dirt in it at first is not infected and if it is radically cleaned out and sewed up, many will heal by primary union. I am convinced that this is the secret of treating brain wounds. Excise all the traumatized brain tissue and sew

up the wound tightly; don't drain. It is the draining of brain wounds that leads to trouble. If there is a large defect in the scalp as well, a skin flap should be swung over from another part of the scalp in order to cover the defect in the skull. In regard to the treatment of simple skull fractures our views are more settled. With improvement in technique and a better understanding of the mechanics involved in the production of fractures as well as appreciation of the fact that the most serious feature of a cranial fracture is the injury to the intracranial contents, the results have been steadily improving.

Men differ as to their operative indications, but not as much as formerly. A carefully done decompression in which the brain is not traumatized and in which intracranial tension is reduced by removing cerebrospinal fluid is often the only operative procedure that is required.

In every children's clinic a considerable number of patients are mental deficients, many of them also having various types of spasticities. One or two men have claimed that many of these cases have choked disc and increased pressure in their spinal fluid, and that a decompression operation cures or greatly improves them. I have looked for a long time for such cases in the large pediatric clinic that I have had at my disposal, but thus far have never seen one. Therefore, I hesitate to recommend this procedure. Occasionally, however, these cases have localized collections of fluid due to some birth injury, and if this is removed they are helped surprisingly.

Brain tumors constitute the most important and most interesting, though not the largest group of cases. It is true, as I said in the beginning of my remarks, that results are not as good as in other cranial cases, but they are steadily improving. Why this difference in results, and can we correct this difficulty? The results can certainly be improved, but to accomplish that we need the help of the general practitioner. They are the men who see these cases first and it is up to them to see that they get prompt relief. Now why does the general practitioner delay? For three reasons: (1) Because his books all tell him that a case of brain tumor has three cardinal symptoms—headache, vomiting, and progressive loss of vision. (2) He was taught in his school days that brain tumors are very rare conditions and that headaches of intracranial origin are usually due to syphilis. (3) Because he thinks an operation on the brain is so dangerous that as a conscientious physician he is afraid to recommend it.

First, as to these three cardinal symptoms. Many brain tumors reach an advanced stage before they show any of these symptoms. In certain patients they never are prominent; that is particularly true in children, and when the tumor is located in the anterior fossa or pituitary region. Frequently the only one of these three general symptoms that is complained of is headache. Now we all know that countless other conditions cause headache. What I would urge upon you is not to put brain tumor as a possible cause of this symptom so far down on your list that by the time you come to consider that as an etiological factor, weeks or months of precious time have been lost. Then, too, I trust the time is not far distant when practitioners generally will use the ophthalmoscope with as great ease as they now use the stethoscope and the microscope, for before, *often long before* a patient notices impairment in vision, the ophthalmoscope reveals a beginning choked disc. Whenever we see a patient with some progressing nervous disorder we ought to look at the case early from the neuro-surgical angle to determine whether or not we are dealing with a tumor.

Secondly, if such a case with a progressive disorder has a negative Wassermann, it is as wrong to give that patient antisyphilitic treatment as it is to give the patient with a ruptured appendix and spreading peritonitis a hypodermic of morphine to relieve his symptoms. *There is no curative value in such a procedure.* If, for some reason in spite of the negative

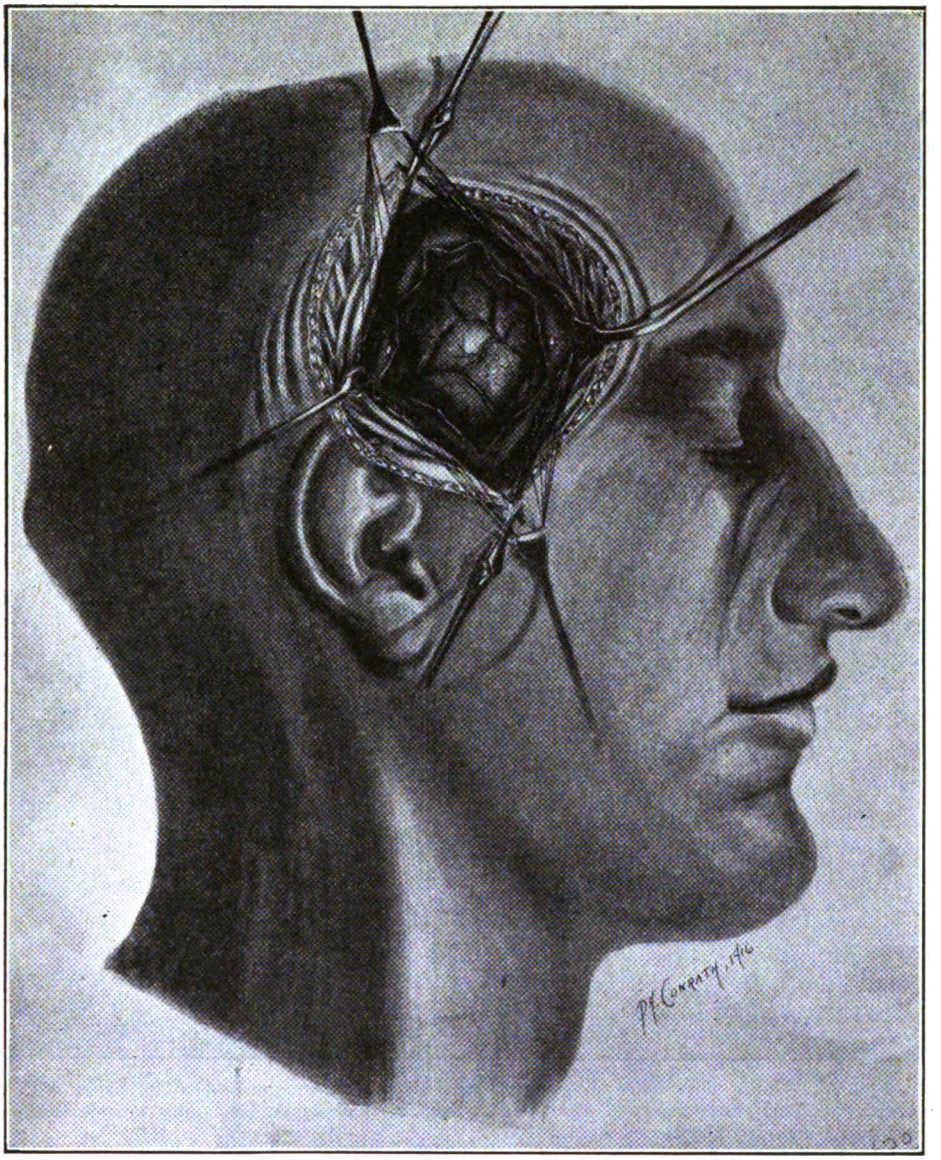


FIG. IV—This shows the method of placing the first layer of sutures in the temporal muscle prior to opening the dura. Sutures are retracted while the dura is incised; this is a very useful procedure when there is marked pressure, as the brain can be rapidly covered by a protective layer of muscle before it ruptures. Silk sutures are used throughout. Whenever possible, cerebro spinal fluid should be removed, however, before the dura is opened, so that the brain will not bulge. Note the numerous radial incisions in the dura in order to completely relieve the tension. The opening in the dura should be so large that the brain pulsates freely. In every decompression the dura must be left open.

Wassermann, you try specific treatment, do it intensively, and if marked improvement is not noticeable in two or at most three weeks, you may be quite certain that your patient's trouble is not due to syphilis.

Thirdly, cranial operations should not and do not have the high mortality they used to have. The factors that have brought about this change are:

1. The development of a technique for operations on the nervous system that is different than that used elsewhere in the body and which is designed to deal with these special tissues.

2. A trained corps of assistants who are familiar not only with this special surgical

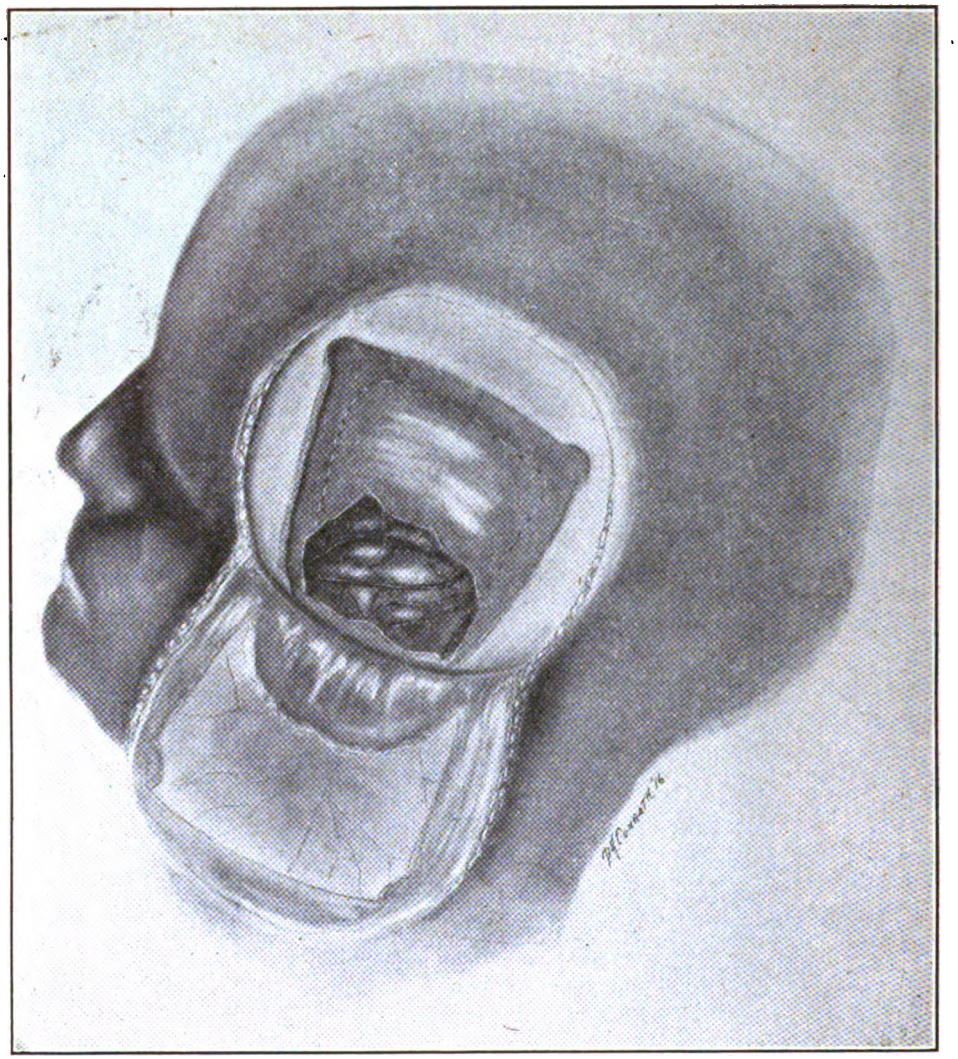


FIG. VII—This shows the method of combining a subtemporal decompression with an osteoplastic flap. Note the way the bone is rongeured away so that only muscle lies over the brain which is unprotected by the dura.

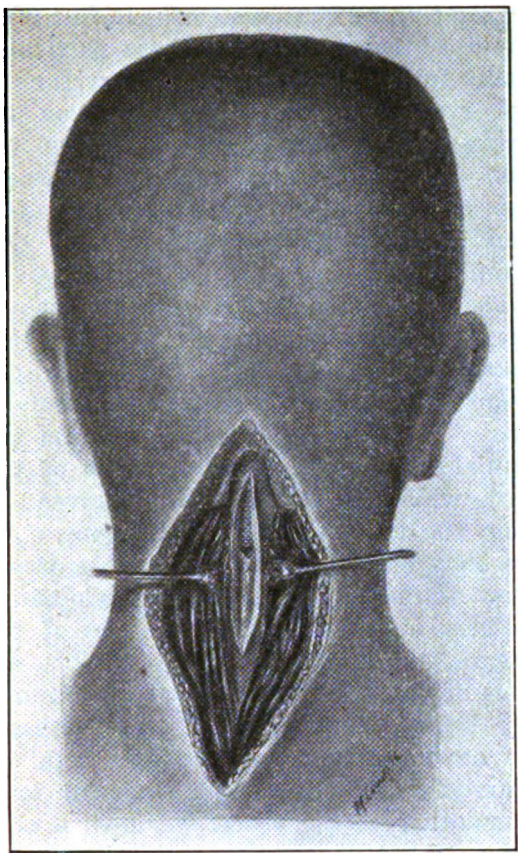
technique but who are well grounded in the anatomy and physiology of the nervous system.

3. Multiple operative procedures with the idea of first relieving increased intracranial tension before attempting a tumor extirpation.

4. Last, but very important indeed, an expert anesthetist who gives an even and much lighter anesthesia than is ordinarily used in abdominal surgery.

Thus far I have considered but a small portion of the nervous system, for the spinal cord and peripheral nerves offer numerous problems. There are four groups of conditions that develop in the spinal cord that are surgical: First, fractures and dislocation of the vertebral column; second, tumors; third, the localized chronic meningitides; fourth, spastic conditions of unknown origin.

The views about traumatic lesions of the cord vary a good deal. The usual advice is not to operate if the cord has been completely cut across, but if there is compression, usually to explore. All these authorities neglect to tell us, however, how to distinguish a complete anatomical division of the cord from one which is compressed but not cut across, and for a very



FIX. IX—The method of exposing the basal cisterna and the floor of the fourth ventricle in order to relieve an obstructed foramen of Magendie. This can be very readily extended into a cerebellar exposure of the entire posterior fossa.

good reason. In the first twenty-four hours there is *no* way of distinguishing whether a complete paraplegia is due to a blocking of the nerve paths or an actual division of the cord. The blocking of the nerve paths is due to hemorrhage or œdema into the cord; if this is not relieved promptly, that is within forty-eight hours at the longest, degenerative changes set in; therefore, to help them they must be operated early and I believe all these cases should be explored in the first twenty-four hours, even though some cases will be operated upon that have had their cords completely severed.

Every spastic paraplegia whose Wassermann on the spinal fluid and cell count are negative, on whom one can demonstrate any evidence of a focal lesion, should be explored, and unless he has been explored, he has not had his fair chance at recovery. Both tumors and localized or so-called serous meningitides may be cleared up by operation.

In certain cases, spasticity may be relieved by cutting some of the posterior spinal roots.

Spinal operations are perhaps not dreaded quite as much as cranial operations, but they also are supposed by many to have a prohibitive mortality. Our experience does not justify that idea. In thirty cases we lost three and one of these died of angina pectoris three weeks after operation.

Of the operations on the peripheral nerves, little need be said except that with an improved technique and careful attention to the minute details nerve sutures are yielding better results than heretofore. Probably no single group of cases is having more light shed upon them in the war than these.

(At this point a number of slides were shown by which the author emphasizes some of the factors that have tended to increase the scope of this work.)

In conclusion, I should like to point out that with better results in these cases the general practitioner will become more interested in the neurological aspect of his cases and come to realize that the diagnosis of neurological conditions is not an insurmountable difficulty. In addition, he will have a group of cases which he formerly classes as hopeless to whom he now may hold out the prospect of relief.

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Pulmonary Tuberculosis: Its Nervous Manifestations.

C. S. KENNEY, M.D., Norton, Kansas.

Read at the Fifty-second Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

There would be no excuse to take up your time nor further add to the volumes that have been written on the subjcet of tuberculosis were it not that I have the conviction that the nervous and mental phase of this disease has been sadly

neglected. Being a chronic disease of the masses, many have been the contributions since the days of Hippocrates; but, until quite recently, little attention has been paid to the explanation of the mental, psychic, and nervous manifestations of this malady. It is my intention, therefore, to set forth, briefly, some of the observations that have been made by careful observers, especially Eppinger, Hess, Gaskell, Cannon, Higier, Schœffer, Pottenger, Lapham, etc. Much has been written about tuberculosis and syphilis, two prevalent chronic diseases, one called the "great white" and the other the "great red" plague. All of us have been admonished to carefully consider each of these diseases before making a diagnosis of any obscure chronic diseased condition. We are now, more than ever before, beginning to appreciate that each has a great bearing on the physical, moral, mental, and nervous manifestations of its victim. Heretofore, the psychic, mental, and nervous manifestations observed in a tuberculosis sufferer was passed by with but little comment. Hence, no attempt was made to explain them. I believe if these conditions were better understood and more consideration given the sufferers, much of the misunderstanding in the homes of the victims would be eliminated. If the affected person and his friends could fully realize that it is a chronic disease with local and systemic manifestations and that one, so infected, would have these marked disturbances, we will have gone a long way toward solving the problem of caring for a tuberculous individual. Unfortunately, however, the irritability, malaise, weakness, etc., in tuberculosis is not nearly so well understood as it is in syphilis, typhoid fever, or pneumonia.

All of us are more or less familiar with the general nervous system; hence, any minute discussion of its embryology, histology, anatomy, and physiology would be superfluous. We are, in fact, interested in this discussion, only in that portion which controls the general organs of the body. For lack of a better term it is called the "vegetative nervous system." It furnishes impulses for carrying on those particular bodily functions that are necessary for the preservation of life. It acts, as you are aware, without any inter-position of the will. By studying the effects of tuberculosis on this system, one can better understand the various manifestations of this chronic toxemia.

The vegetative nervous system springs from the central nervous system. For this discussion, it may be divided into the greater vagus and sympathetic subdivisions. The greater vagus comes from the cranial-bulbar and sacral divisions of the cord, while the sympathetic is given off from the thoracico-lumbar divisions. All the body organs, with the possible exceptions of the sweat glands, the pilo-motor muscles, and the vascular muscles of the viscera, are innervated by both. The actions of these two divisions are antagonistic; hence, stimulation of one depresses the other. But, when the sum total of stimulation of one equals the sum total stimulation of the other, we have a condition of health which is maintained until one is over-stimulated. Then, the equilibrium is disturbed and a dysfunction results.

To a certain extent, these divisions of the vegetative systems are regulated by the secretions of the internal glands: the vagus by the pancreatic secretions; the sympathetic by the adrenal, thyroid, and other ductless gland secretions. If either is over-secreted, a dysfunction results. It is very interesting to note that toxemia and depressive emotional states, such as fear, anxiety, discouragement, worry, and disappointment, have very similar symptom complexes. This is very easy to recognize in tuberculosis, because it is a disease which manifests so many periods of slight activity, accompanied by a low or moderate degree of toxemia, which disappears after a few days duration; and because it is likewise accompanied by so many of the depressive emotional states, which come and go as the causes which produce them.

The symptoms of toxemia and depressive emotional states are: headache, malaise, nervous irritability, insomnia, lack of endurance, loss of appetite, coated tongue, inhibition of gastric and intestinal secretions and motility, constipation, fever, pallor, and, at times, sweating. All of these symptoms are not always present; but they are, in a sufficient number of instances, to indicate they are the result of a central sympathetic stimulation.

For years we have endeavored to standardize the diagnosis and treatment of tuberculosis, but have only partially succeeded. An early diagnosis is important, so that proper treatment may be established in time to give the patient the best chance to recover. A number of very definite symptoms stand out prominently. They are: malaise, a finicky appetite, a tired feeling, especially early in the morning after a good night's sleep; nervousness, irritability, a delicate hacking cough, etc.

It is certainly sensible to class tuberculosis as *infectious*. We can then understand readily that it is not hereditary, and should take the stand that without infection there can and will be no disease; or, in other words, no infection, no clinical manifestations, hence no disease. Formerly those who were weak and run down were said to have a *predisposition* to tuberculosis. Now we are beginning to understand that there is really not necessarily a *predisposition* to tuberculosis any more than there is to typhoid fever, pneumonia, or other diseases. For years we have used the term, "pre-tuberculous stage," which, like Cæsar's ghost, rises up to plague us. We are now convinced that no "pre-tuberculous stage" exists, but instead the symptoms of malaise, weakness, loss of weight, nervousness, etc., at that period are really manifestations of tuberculosis. We recognize and class this stage today as incipient tuberculosis. Thus, we can dismiss from our minds heredity, predisposition, and the pre-tuberculous stage.

We are able to explain satisfactorily the various manifestations of this disease by a better understanding of the effect of the specific toxins on the vegetative nervous system.

The following symptoms will lead to a positive diagnosis of tuberculosis: A finicky appetite, increase of pulse rate, increase of temperature, changes in blood, hoarseness, tickling in the larynx, circulatory disturbances, chest and shoulder pains, rigidity of muscles, flushing of the face, apparent anemia, frequent and protracted colds, blood spitting, pleurisy, and sputum. These, plus a lagging of the chest on one side, with rigidity or increased muscle tonus over one area of the chest, increased vocal fremitus, localized cog wheel, and localized prolonged high-pitched expiratory sound on one side, point to and compel us to make a tentative diagnosis of tuberculosis.

We have previously stated that when stimulation of both branches of the vegetative system is equal, there is no dysfunction. Tuberculosis is, if anything, a chronic disease. It has one or more foci that cause local irritation of nerve filaments. Later these foci give off toxins which produce the symptoms that have been enumerated. In other words, for years all cells of the body are bombarded by toxic materials which produce a chain of well known symptoms. It is no wonder then that the poor victim is undermined, his strength lessened, and he has a nervous and a mental instability, dyspepsia, with chest and shoulder pains, a hacking cough, and other symptoms. He may look well, but he is a substandard man, unable to assume all the grave responsibilities of life. He is misunderstood. He is self-centered, selfish, and perhaps contrary, showing a peculiar negativism about men and affairs. His strength and ability to toil are over-rated and he is accused of being lazy, finicky, cranky, a neurasthenic, and a *grouch*. The toxins often stimulate the mental faculties, and many are alert in arts, sciences, and literature. They are visionary, self-opinioned, and prone to build air castles; but their strength is not equal to the tasks they assume and they break under the strain, becoming hopeless

wrecks, if nothing is done to stay the process.

Stimulation of the sympathetic system by the toxins produce hypo-secretion, hypo-motility, a fast pulse, etc. If, however, the peripheral stimulation of the greater vagus is in the ascendency, we may expect hyper-secretion, hyper-motility, and a moist clean tongue. These cases are called the vago-tonic type. If the gastric filaments are greatly stimulated, we have a condition of hyper-chlorhydria, often with pyloric spasm, simulating gastric ulcer. In fact, many patients who gave histories of hyper-chlorhydria and gastric ulcer previously, have been admitted to the State Sanatorium at Norton with active tuberculosis. In every instance, they were of the vago-tonic type with a slow pulse, a normal or nearly normal temperature, and good digestion. This type has a favorable prognosis. It is also interesting to note that the vagotonic type also show evidence of irritation of the appendix. In one case observed, a number of attacks of pain that appeared to be an involvement of the appendix were noted. It might be well for us to consider the possibility of tuberculosis in cases of recurrent or chronic appendicitis.

For years we have recognized the fact that a typhoid patient having a slow pulse and a low temperature had a better chance to recover. It is also almost an axiom in tuberculosis that one who has a good heart and a good digestion and who faithfully, hopefully, and willingly submits to treatment, has a better chance for recovery. In as much as the vagus stimulation is in the ascendency, the reason is quite evident. We find in tuberculosis that the functions of all organs are unstable. The pulse, with the patient at rest, is usually slow, but on exercise, during periods of toxemia or depression, becomes rapid. The appetite improves by rest, but it is disturbed by toxins and depressive emotions. In other words, when the toxemias are diminished, conditions improve.

The greater vagus system conserves a healthy tone of the important internal organs. If its stimulation is in the ascendency, it offers the patient increased opportunities for recovery. On the other hand, if the vagus tone is lowered and the stimulation of the sympathetic becomes prominent, the chances grow less, because there is a lessened secretion and motility of the digestive organs, a rapid pulse, irritability, nervousness, etc.

Taking the classification, from Pottenger's Clinical Tuberculosis, we will now consider the symptoms of tuberculosis under three heads:

Symptoms Due to Toxemia	Symptoms Due to Reflex Cause	Symptoms Due to Tuberculous Process per se
Malaise	Hoarseness	Frequent and protracted colds
Feeling of being run-down	Tickling in larynx	Spitting of blood
Finicky appetite	Cough	Pleurisy
Lack of endurance	Digestive disturbances	Sputum
Loss of strength	Loss of weight	Temperature
Nervous instability	Circulatory disturbances	
Digestive disturbances	Chest and shoulder pains	
Loss of weight	Flushing of face	
Increased pulse rate	Apparent anemia	
Night sweats		
Temperature		
Blood changes		

"It will be noticed that this first group of symptoms is expressive of central nerve stimulation; that its action is that of a general inhibition of function; that the symptoms are expressed widely through the body and when taken together form a symptom-complex which is particularly expressive of a general nervous discharge through the sympathetic nervous system." Tuberculosis, however, being so chronic in nature, has its periods of activity and quiescence; hence, these symptoms are not present at all times.

The importance of these symptoms cannot be over-estimated; of especial importance is malaise, the tired feeling, espe-

cially in the morning after a good night's rest, the nervous instability, dyspepsia, and the neurasthenic tendencies, which are often diagnosed as neurasthenic. We wonder if neurasthenia should not be called a condition and not a disease; if it does not have a physical basis, often tuberculosis, and if by rest, the underlying cause is removed, the symptoms disappear. We also wonder how many lean, sallow, cranky, flat-chested dyspeptics are not really suffering from the toxemias of tuberculosis, instead of from some disturbances of the digestive apparatus *per se*.

The symptoms, due to reflex causes, result from a stimulation of the greater vagus at the periphery. This explains the chest pains, flushing of the face, hoarseness, tickling in the throat, and a slight hacking cough, especially that delicate little hack that many euberculous patients employ in clearing the throat. We should, in all cases, make a thorough physical examination of all chests before making the diagnosis of throat trouble. I believe, if we do this, many undiagnosed cases of tuberculosis will be discovered and a far less number of tonsils will be sacrificed in a vain effort to relieve a cough. Of course there are many symptoms due to diseased tonsils, but I fear snap judgment is too often taken. The tonsils are enucleated often to relieve symptoms in the throat but the patient does not improve. The symptoms become more pronounced and, in time, a complete breakdown, which every one recognizes as tuberculosis, results. In the institution we have treated several who came with a similar history, having been treated for various ailments which proved later to be tuberculosis.

Chest pains and increased muscle tone or rigidity of chest muscles are reflex symptoms that point to an infection beneath the chest walls. We have for years expected to find an infection in or adjacent to the appendix with pain and rigidity over McBurney's point. If, then, pain, rigidity or increased tension of the muscles in this region, a rise of temperature and an increased pulse rate, and toxic symptoms of malaise with dyspepsia and nausea point to a diagnosis of appendicitis, why does not the same symptoms indicate an infection of the lungs, when the symptoms are in the chest rather than in the abdomen?

A patient that is slightly ill with a pain in the abdomen receives a careful examination and an attempt is made to diagnose his case properly. Are we as careful when one comes to us with malaise, neurasthenia, dyspepsia, and chest pains, or do we pass it off lightly as a "dyspepsia," "nervousness," "malaria," or a "run-down condition"? The conditions are identical and one may be diagnosed as easily as the other. We are, however, slow in establishing a definite basis for diagnosing tuberculosis. We have a few classical symptoms in appendicitis, gall bladder infection, and typhoid fever, that are well understood. I believe, if we take two or three symptoms from the toxic group, one or two from the reflex, and one or two from the class of tuberculous process *per se*, and add these to two or three definite signs found on physical examinations, we will be in good position to make a diagnosis of pulmonary tuberculosis fairly early.

To me the nervous and mental side of this subject is very interesting, and in conclusion I wish to make an appeal to you to further observe the effects on the progress of each case by this bombardment of the vegetative nervous system by the toxins produced by this chronic, infectious disease.

At the State Sanatorium we made observations relative to the constancy of the symptoms in these three groups and were impressed with their reliability.

100 per cent had malaise.
100 per cent had disturbances of digestion.
96 per cent had sputum.
96 per cent had cough.
96 per cent clearing of the throat.
92 per cent pleurisy.
96 per cent chest pains.
68 per cent spat blood.

Some one has said that at twenty many of us have the disease that will kill us at forty. We can go further than that and say that at ten many of us have the disease from which we will suffer at intervals during our life and finally die of it, unless we take pains to arrest it. I refer to tuberculosis. Many a child has had the slight rheumatic attacks known as growing pains, has then developed chorea or St. Vitus' dance, together with some involvement of the heart, and died at the age of forty or so with heart trouble. Many a child has suffered with an attack of scarlatina, perhaps very mild in the immediate symptoms, developed a complication of the kidneys, and died at forty or thereabout of Bright's disease. Many a child has been infected with tuberculosis; perhaps he grew up puny, with a bright eye, was irritable, and was subject to bronchitis and colds. Maybe he had a tuberculous exacerbation which is called pneumonia, or typhoid. He makes a slow recovery from that but for years he has dyspepsia, and a little hacking cough. Finally he dies from tuberculosis, or as people say, consumption, at forty or thereabout.

In other words, the red strand connects all diseases of the child and adult, and the mitral heart death resulted from the early growing pains by well recognized steps and pathological changes; and the uremic death resulted from the previous "scarlet rash" in the same way.

Now we know that, in the majority of instances, the death from consumption usually results from a long continued series of changes initiated during childhood days.

As Von Behring has said, "Consumption is but the end of the lullaby that was begun at the cradle of the victim."

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Clinical Eponymic Signs.

(Continued from Page 199)

OPPENHEIM'S SIGN—Contraction of the tibialis anticus, extensor hallicus longus, extensor digitorum communis, and sometimes of the peroneal muscles on stroking the median surface of the leg at the posterior margin of the tibia from above downward; seen in spastic conditions of the lower extremities.

OPPOLZER'S SIGN—On palpation the seat of the apex-beat is found to change with the alteration of the patient's posture in cases of serofibrinous pericarditis.

OSLER'S PHENOMENON — The agglutination of the blood-platelets observed in blood immediately after its withdrawal from the body.

PARKINSON'S SIGN—An immobile, mask-like expression in paralysis agitans.

PARROT'S SIGN—Dilatation of the pupil when the skin is pinched; it is noted in meningitis.

PASTIA'S SIGN—Transverse lines, usually two or three, in the fold of the elbow in scarlet fever. They are rose-red at first but later turn dark red or wine-colored. They are visible before the appearance of the rash, remain through the eruptive stage, and continue after desquamation.

PAUL'S SIGN — Feeble apex-beat, with forcible impulse over the body of the heart, in adherent pericardium.

PEREZ' SIGN—A loud friction murmur heard over the sternum when the patient raises his arms, especially the left, over his head and lets them fall again; it is noted in cases of aneurysms of the arch of the aorta and mediastinal tumors.

PFUHL'S SIGN, P.—JAFFE'S SIGN — In subphrenic pyopneumothorax the liquid issues from the exploratory puncture or incision with considerable force during inspiration, while the contrary occurs in true pneumothorax.

PILCZ' SIGN—WESTPHAL-PILCZ' PHENOMENON—Contraction of the pupil, followed by dilatation, after vigorous closing of the lids; caused by tension of the orbicularis muscle.

PINARD'S SIGN—After the sixth month of pregnancy, a sharp pain, upon pressure over the fundus uteri, is frequently a sign of breach presentation.

PINS' SIGN—A sign seen in pericarditis, consisting of disappearance of the symptoms that stimulate pleurisy when the pa-

tient is placed in the knee-chest position.

PIOTROWSKI'S SIGN — Percussion of the tibialis muscle produces dorsal flexion and supination of the foot. When this reflex is excessive it indicates organic disease of the central nervous system.

PITRES' SIGN—(1) "Signe du cordeau." The angle formed by the axis of the sternum and the line represented by a cord dropped from the suprasternal notch to the symphysis pubis indicates the degree of deviation of the sternum in cases of pleuritic effusion. (2) Hyperesthesia of the scrotum and testes in tabes dorsalis.

POOL-SCHLESINGER'S SIGN—A spasm of the extensor muscles of the knee and of the muscles of the calf in tetany.

PORRET'S PHENOMENON — When a continuous current is passed through a living muscular fiber the sarcous substance shows an undulating movement from the positive toward the negative pole.

PORTER'S SYMPTOM — Tracheal tugging. See Oliver's Symptom.

POTAIN'S SIGN—Extension of percussion dullness in dilatation of the aorta from the manubrium to the third costal cartilage on the right-hand side.

POTTENGER'S SIGN—(1) Intercostal muscle rigidity on palpation in pulmonary and pleural inflammatory conditions. (2) Different degrees of resistance on light touch palpation, noted (*a*) over solid organs when compared with hollow organs; (*b*) over foci of disease in the lungs and pleura when compared with that over normal organs.

PREVOST'S SIGN—Conjugate deviation of the eyes and head, which look away from the palsied extremities and toward the affected hemisphere. It is noted in cerebral hemorrhage.

PSEUDO-GRAEF'S SIGN—Slow descent of the upper lid on looking down, and quick ascent on looking up; seen in conditions other than exophthalmic goiter.

PUTNAM-DANA'S SYMPTOM-COMPLEX — Combined sclerosis of the lateral and posterior columns of the spinal cord.

QUINCKE'S SIGN—A blanching of the finger nails at each diastole of the heart; seen in aortic insufficiency.

QUINQUAUD'S SIGN — Trembling of the patient's fingers, felt when his fingers, spread apart, are placed vertically in the palm of the examiner's hand; said to be a sign of alcoholism.

RAMOND'S SIGN—Rigidity of the erector spinae muscle indicative of pleurisy with effusion. The rigidity relaxes when the effusion becomes purulent.

RASCH'S SIGN—Fluctuation obtained by applying two fingers of the right hand to the cervix, as in ballottement, and steadying the uterus through the abdomen with the left hand. It depends upon the presence of the liquor amnii, and is an early sign of pregnancy.

RAYNAUD'S SIGN—Dead-finger; a cold, pale condition of the fingers and toes, alternating with heat and redness. It is an early symptom of symmetric gangrene.

REDER'S SIGN—A tender point on the right side above O'Beirne's Sphincter; seen in appendicitis.

(To Be Concluded)

War Work for Young Women.

The Surgeon General's Office, War Department, has issued an urgent call for young women to serve in reconstruction hospitals at home and abroad. The Normal School of Physical Education, Battle Creek, Michigan, which is affiliated with the Battle Creek Sanitarium, wishing to do its share toward winning the war, has inaugurated a course in physiotherapy, which meets the requirements of the War Department. Courses begin October 1 and February 1. Length of course is four months. The curriculum consists of Anatomy, Physiology, Hygiene, Bandaging, Active and Passive Movements, Hydrotherapy, Massage, Electrotherapy, and Clinics.

The medical profession are asked to direct the attention of young women who are planning to engage in war work to this unusual opportunity.

Further information may be obtained from Frank J. Born, M. D., Director of the School.

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W. E. McVEY, M.D. - - - - - Editor

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Anomalous Ethics.

The newspapers of Kansas generally reflect the sentiment of the great masses of the people in strongly supporting every effort to prevent the use of alcohol and alcoholic liquors in the state. They are apparently jealous of their reputation in this respect and would resent any inference that they were half-hearted in their support of the principles of prohibition. Alcoholic beverages are carefully barred from their advertising pages, and from their reading columns everything is scrupulously excluded that does not harmonize with the strongest sentiments on the subject of prohibition.

It does not strike the average reader that there is any inconsistency in the fact that large amounts of advertising space are given to the advertising of patent medicines, and that columns of reading matter are used to extol the virtues of patented remedies whose principle or only virtue lies in their alcoholic content, which varies from 14 to 20 per cent. There is nothing in the name which suggests, and nothing in the literature which informs the reader, that it contains alcohol in any amount.

Endorsing these remedies and proclaiming to the public the great benefits they have derived from their use, will sometimes be found the names of ministers, lawyers of note, well known politicians and women of social and literary distinction, men and women whose reputations for sobriety have been well established and whose sentiments on the subject of prohibition can not be questioned. Such people would be shocked if convinced that the agreeable effects they had observed were due to the alcohol they had imbibed in those remedies.

But the newspapers, the leaders of public opinion—have they been negligent in their scrutiny of the matter which fills their columns, or have they been wilfully careless in that regard? Or perhaps they are not yet convinced, as at least some of the members of our profession seem to be, that alcohol has no place in medicine.

If the moderate use of alcohol is harmful, or injurious to health, then the newspapers are responsible for whatever injurious effects may be caused by the use of patent medicines made up with wine or other alcoholic liquor and a negligible quantity of drugs of indefinite or no therapeutic action. Ignorance of the contents of these remedies is no excuse, for the alcoholic content of any of them may be easily obtained, and the relative importance of other ingredients may be readily learned from the Board of Health. If such a use of alcohol is injurious, the newspapers in the state should be prohibited from advertising those patent medicines containing large quantities of alcohol and druggists should be prohibited from selling them.

If such use of alcohol is not injurious, if alcohol judiciously administered has any medicinal value, physicians should be permitted to prescribe or dispense it in such form and at such times as their judgment determines the need.

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Can the Old Physician Come Back?

Most men who have practiced medicine for from twenty to thirty years begin to slow down. They accomplish less work, they are less thorough and systematic in their examinations—depending more upon

intuition or observation perhaps—and are prone to follow along the older lines of treatment. They may be no less successful as practitioners than the younger men in the profession, for their experience is of great value to them. But they depend too much upon it, they study less, and are less ready to accept new ideas than in their younger days. In a few years they have fallen behind and realize it. They are unable to discuss medical topics in modern terms and along progressive lines, and they fall out of touch with the younger and more aggressive men. While they have stood still medicine has advanced by rapid strides.

The old man who has slowed down—perhaps stopped for a time—can come back if he will, but it means an amount of perseverence which few of us have, and an endless amount of work which few of us are willing to undertake. The medicine of today is written in a different language from the medicine of thirty years ago, and it would be impossible for the man who stopped then to get much out of it. Those who have trailed a little, but who have kept up communicating lines with the vanguard, will have some difficulty in catching up, but when they come in sight of the main drag their courage and enthusiasm will carry them on.

One may go to medical centers for a few weeks and in the clinics there pick up a little interest and perhaps learn a few of the newer methods of doing things—get a little stimulation, at least—but that is not enough for the man who has fallen behind. There is a great deal lying along the road between his last stopping place and these clinics that he must pick up, if he really comes back. He will need a new library and will need to give it very thorough and systematic study. He will need to study some physiology and particularly what has been discovered in regard to the internal secretions. He will need some physiologic chemistry and he will find a great deal of new material along the line of dietetics. If he is to put himself in touch with modern medicine, he will need to read a great deal of material on infection and immunity. In addition to all this, one will need to follow very closely a few of the best medical journals.

A great deal of time for reading and study is required by every physician who keeps up with medical progress, and the man whose business is so large that he has no time for study soon gets out of the habit, he falls behind in his diagnosis and his treatment, his business gradually drops off, and then he has a chance to try to come back. One wonders if it is preferable to do a moderate business for a lifetime or to do a very large business for a dozen years and then retire.

In the latter case, especially if one has earned and laid by a competence, he may retire and enjoy himself according to his tastes, at any rate he does not need to depend upon his practice for a living. However, although everyone plans and looks forward to it, very few, whether financially able or not, ever reach that time when they are willing to retire from the practice of medicine. The few who have retired are not happy or contented and would welcome an opportunity to take up the work again—if they could.

The man who does a moderate business rarely finds himself in a financial situation that will permit of voluntary retirement, but he has had time to keep up his studies, and, if he has done so, will be happier than the man who has earned a competence at the expense of his mental equipment, whether he retire or not.

Room for All.

Those who ascribe other motives than duty and patriotism to those physicians who have given their services in the war are only to be found among those who, for various reasons, are still at home.

It has been suggested that many see in the war a chance for advancing their professional standing and increasing their business when the war is over. Perhaps so, but we are willing to credit them with a lot of patriotism mixed with good business foresight. At any rate, the men who

give up their practices to care for the sick and injured soldiers, both here and over there, are entitled to every honor bestowed upon them and every business advantage coming to them when the war is over. If you don't feel like clapping your hands and shouting when one of our Kansas boys in the service over there gets an honorable preferment, an advancement in rank or a Croix de Guerre—go take something for it and try to come clean.

Those who are unable to get commissions in the army will have plenty of work to do at home for the next few years, and if they devote their time and thought to it will no doubt be quite willing to surrender a part of their business to the boys when they come back. It seems to be the general impression among the older men who stay at home that the end of the war will be the end of their usefulness in the practice of medicine. There is really no ground for such a gloomy outlook. For some years the annual output of the medical schools has hardly been sufficient to replace the practitioners who have died and supply the requirements for the steadily increasing population. The number of graduates in medicine will necessarily be short of the requirements for several years to come. When our soldiers come home and the medical officers take up the civilian practice again, there will be room for them without crowding out the old fellows who were compelled to fight the battles at home.

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Our Advertising Space Is Appreciated.

Believing that you will like to know how your Journal stands with the advertisers, we publish herewith an extract from a letter received a few days ago from one of them:

"Through the constant use of the advertising pages of your Journal, the Publishers' Adjusting Association has built up a collection business among physicians and surgeons that we claim is without a parallel in medical annals. Last year, for instance, accounts placed with us aggregated one million dollars. We attribute a large portion of our success to the use of your Journal, and it is our belief that anyone having a message for the medical fraternity can do no better than to place the same in the advertising space of your Journal.

"The growth of the business of our medical department has been such that the officers have determined to designate the department hereafter as the Physicians and Surgeons' Adjusting Association, owned and operated by the parent organization, whose entire assets are behind the department. The same efficient collection service will be given in the future as in the past and we anticipate that with the new name, our friends and patrons will more easily grasp the scope and worth of our service."

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Major Gray.

Dr. Geo. M. Gray, who early in the year was commissioned a Lieutenant in the Medical Reserve Corps and assigned to duty as medical aide to the Governor, has recently been promoted to the grade of Major.

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Excerpts—By The Prodigal.

In the July number of this Journal Dr. H. M. Richter, of Chicago, relates his war experience in a German base hospital. He says, "In 1916 Germany was not using any means of disinfection. The wound was opened up very widely and packed with gauze without any idea of disinfection." It would be a favor if the Doctor would tell us what the mortality was with such treatment, as compared with the same class of wounds treated in the base hospitals of the Allies. It may have been a coincidence, but in the same paper the Doctor says, "In one of the earlier wars a part of the English army was cut off by the enemy and 500 were wounded. They were kept away from the main army for fifteen days. They had no dressing, no antiseptics, and only one surgeon. It was impossible to give attention to all the wounded, so finally the men were allowed to do as they pleased. They bathed their wounds in the water of a near-by running brook. After fifteen days they got back to the main lines and found that the total morbidity and the total mortality of the

little band away from the main army was far below the morbidity and mortality of the others." The treatment of these 500 wounded English was medieval, but the results were scientifically up to date—civilized. They were fortunate in not having more surgeons with them. It shows that there were professional meddlers in those days. The results justified the practice of open treatment of wounds. The function of a doctor is to learn what Nature wants to do and help her. If he does not know what Nature wants and tries to do something, he is sure to do the wrong thing. Asepsis protection and non-interference with Nature insures success in the treatment of wounds.

The success of a physician depends on his ability to differentiate between that which is truthfully told and the truth of that which is told. A good judge of human nature with a little definite knowledge makes a safer and more successful practitioner of medicine than a thorough knowledge of medicine and little knowledge of human nature. That is the reason it is said that a doctor is born, not made. Any ordinary human intelligence can be taught and learn medicine, but to be able to understand and comprehend the workings of the human mind is more or less an intuition. The same principle holds good in mathematics, in music, and in the sciences and arts. A good diagnostician is a good judge of human nature. He gets the confidence of his patience by his confiding and listening attitude, convincing him that the doctor believes him, and the patient becomes a willing subject. He places implicit confidence in such a doctor and confidence and the first and essential element of success in restoring the patient to health. On the same principle that a physician may succeed if others do not have confidence in him, he cannot succeed unless he has confidence in himself. This self-confidence—not egotism—begets confidence in others, is psychologically imparted to the patient. And since a vast majority of diseases are self limited, palatable agents can be given, even placebos, and the doctor need not be haunted with a fear that he has made his patient worse or killed him.

The doctor who studies himself thoroughly, puts himself off to one side and mirrors himself without prejudice, measures himself by watching and associating himself with those who are failures as well as the successful physicians will be able to avoid the quicksand of failure and to build on some solid rock of success to a great degree and make up to some extent for his lack of intuition.

The success or failure of a physician is measured by the percentage of his mortality table.

"The strongest motive action, the most powerful mainspring within us all, is the sexual desire. It is stronger in its influence, controls more men, causes the commission of more crimes and more good deeds than any other impulse."

Is This True?

Baldheaded men and billy goats are immune to tuberculosis.

One On the Topeka Examining Board.

The little Irishman was being examined for admission to the army. He seemed all right in every way except one. The doctor said, "You're a little stiff." Instantly the Irish blood boiled as the applicant replied, "You're a big stiff."

Dr. Munn and His Auto.

When Dr. Munn got his first auto he couldn't run it very well, but his folks and friends wished to see how it would work as soon as possible. He loaded the machine to its capacity and started out toward Rossville. Everybody was delighted and Munn was proud to know that he could drive so well without getting into trouble. But after while all decided it was getting late and time to turn homeward. It then dawned on Munn to his horror that he did not know how to turn

the machine on a country road.

"Sorry, but I'll have to keep on going until we come to a town," said Munn. "I know how to run around a block." He kept on going fourteen miles before he found a town (Manhattan) that he could turn around in.

UNANSWERED.

Little girl entertaining the lady caller while her mother was dressing.

Little Girl to Lady: "Have you a little girl?"

Lady: "No, dear, I have no little girl."

Pause.

Little Girl: "Have you a little boy?"

Lady: "No, dearie, I am sorry to say I have no little boy either.

Long pause.

Little Girl: "What are yours?"

It is claimed that only about five per cent of the lower animals are defective at birth. This is a better showing than the "genus homo" can make.

Oculists have found that a peculiar kind of eye strain is caused by persons reading while lying down. That would be called reclining or horizontal heterophoria, I suppose.

It is essential that every practicing physician should be able to diagnose iritis and glaucoma.

It is not so much in knowing a whole lot as in knowing a little and how to use it that counts.

A good doctor is a close observer and hence can see things at a distance. He avoids future trouble by meeting it now.

IF YOU HAVE A COLD
WEAR A MASK.

They are doing it in Europe.

The diseases most feared by the armies in Europe are those developed from coughs and colds. They are communicated mainly in conversation. Spanish influenza is one of the diseases prevalent over seas and America will in all probability have its turn the same as the Russian epizootic and the pink eye here in the 70's.

A doctor who never does any more than he gets paid for never gets paid for any more than he does, and the world soon gets onto his curves.

Progress and advancement in a profession is made by men giving more to the profession than they get out of it.

The late Robert G. Ingersoll asked, "Why is good health not contagious as well as disease?" That question was asked over a quarter of a century ago. The present day physician would answer, "Good health is contagious."

A happy physician brim full of vitality and suggestive treatment at the psychological time makes health contagious. The practice of medicine and surgery has no place for a puny, sickly, crabby, grouchy, neurasthenic doctor.

The safe and successful physician and surgeon studies how little he can interfere with Nature in the treatment of his patient. The fussy meddlesome doctor tries to interfere with Nature and show her that he can beat her, hands down—and fails.

BOOKS.

1917 Collected Papers of the Mayo Clinic, Rochester, Minnesota.

Octavo of 866 pages, 331 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $6.50 net.

The 1917 collection of papers of the Mayo Clinic is fully up to the standard of the former editions. It is a high class publication in every way. The plates are numerous and of excellent grade.

These papers cover a great variety of subjects and all are intensely interesting. It is impossible to select a few that are more worthy of mention than the others, nor does space permit us to give particular notice to all of them. One who wishes

to know what is going on in the medical world will do well to read this collection.

The Hospital as a Social Agent in the Community.

By Lucy C. Catlin, R.N., Director of Social Service Work and Executive Director of the Out-Patient Department of Youngstown Hospital, Ohio. 12-mo of 113 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $1.25 net.

The author has presented in a very convincing way the great importance of the social worker in connection with hospitals. Whether the hospitals shall assume the direction of the social worker, become, in other words, the social agent, does not seem to be so definitely established. Illustrative cases are related which bring out very clearly the close relation between the social and medical needs of the unfortunate. The genuine sympathy of the author for the cause she has so ably espoused is manifest throughout the book.

A Laboratory Manual of Qualitative Chemical Analysis.

By A. R. Bliss, Jr., M.D., Ph.G., Professor of Pharmacology, School of Medicine, Emory University, Atlanta, Ga.; formerly Professor of Chemistry and Pharmacology, Graduate School of Medicine, University of Alabama. Second edition, revised and reset. 194 pages, with working tables. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $2.25 net.

This book is particularly adapted to the needs of the students in dentistry and medicine and will facilitate the laboratory courses required of them. In the arrangement of the text the author has been able to utilize space to the best advantage. The tests for each member of a group are first given and then the procedure for the separation of that group. It is condensed into a small volume that yet seems to contain all that is essential for the student's instruction.

The Treatment of War Wounds.

By W. W. Keen, M.D., L.L.D., Emeritus Professor of Surgery, Jefferson Medical College, Philadelphia. Second edition, reset. 12-mo of 276 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $2.00 net.

The second edition of this little book, following so closely upon the first, is indicative of the demand created for it. The second edition has been rewritten and is practically a new book. A considerable amount of space has been given to the Carrel-Dakin method of the treatment of wounds.

It is needless to say that Dr. Keen's effort will be much appreciated by those in the service as well as those who anticipate entering the army.

The Medical Clinics of North America.

Volume 1, No. 6. (The Southern Number, May, 1918.) Octavo of 224 pages, 35 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Published bi-monthly. Price per year, paper, $10.00; cloth, $14.00.

In the Southern Number of the Medical Clinics will be found reports of clinics held by McElroy of Memphis, Bel of New Orleans, Minor of Ashville, Fontaine of Memphis, Bass of New Orleans, Wilson of Charleston, Gibbes of Columbia, S. C., Paullin of Atlanta, Monroe of Charlotte, N. C. There are also contributions by Major McLester, M. R. C., Royster of Norfolk, Snyder of Birmingham and Deaderick of Hot Springs.

The subjects treated are all of general medical interest.

The Surgical Clinics of Chicago.

Volume II, Number 3 (June, 1918). Octavo of 253 pages, 62 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Published bi-monthly. Price per year, paper, $10.00; cloth, $14 00.

In the Surgical Clinics for June will be found the usual number of very interesting reports. Of particular interest to all of us is the clinic by Eisendrath on "Injuries of the Chest in Civil Life and War." A variety of cases were shown and the report is illustrated with a number of very excellent plates.

One of the very timely articles is by E. H. Ochsner on "Potential and Acquired Static Flatfoot." Methods for correction are described and well illustrated.

In this number will also be found a very interesting clinic by Shambaugh on "Surgical Affections of the Nose, Throat and Ear."

Clinical Diagnosis.

A manual of laboratory methods. By James Campbell Todd, M.D., Professor of Pathology, University of Colorado. Fourth edition, revised and reset. 12-mo of 687 pages with 232 text-illustrations and 12 colored plates. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $3.00 net.

This book is of convenient size for the

use to which it is to be put, and the text is sufficiently concise to make it valuable for office or laboratory purposes. There is an introductory chapter on the use of the microscope in which one will find some very serviceable suggestions. Following in regular order are described the methods for examining the sputum, urine, blood, stomach contents, feces. Then there is a chapter on animal parasites, one dealing with miscellaneous examinations, one describing bacteriological methods, one concerning the preparation and use of vaccines, and a chapter on sero-diagnostic methods.

Diseases of the Male Urethra.

By Irvin S. Koll, M.D., Professor of Genito-Urinary Diseases, Post-Graduate Medical School and Hospital, Chicago. Octavo of 151 pages, with 123 illustrations, several in colors. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $3.00 net.

After describing the anatomy of the male urethra the author gives a short history of gonorrhea, then discusses the bacteriology, pathology, symptomatology, diagnosis, course and treatment of the disease. A chapter is devoted to the complications of gonorrheal urethritis, a chapter to stricture, one to non-gonorrheal urethritis, and one on urethrorrhea, prostatorrhea and spermatorrhea. A chapter is devoted to tumors of the urethra and finally the subjects of impotence and sterility are discussed.

Volunteer Medical Service Corps.

The Council of National Defense authorizes the following:

Many thousands of blanks for enrollment of the legally qualified men and women physicians of the country in the reorganized Volunteer Medical Service Corps are being mailed by the Chairman of the General Medical Board of the Council of National Defense. With the blank are enclosed a letter and a folder giving all details as to the organization.

The blank which applicants are asked to fill out reads:

APPLICATION FOR MEMBERSHIP IN THE VOLUNTEER MEDICAL SERVICE CORPS AUTHORIZED BY COUNCIL OF NATIONAL DEFENSE.—APPROVED BY THE PRESIDENT OF THE UNITED STATES.

(Spaces for date, full name, street, city and state addresses.)

1. Date of birth.
2. Place of birth.
3. If foreign born, when did you become a resident of the United States?
4. When and where naturalized? How?
5. Are you single, married, widowed, or divorced? Nationality? Color? Height? Weight?
6. State high school, academy, college, or university you have attended, with dates of attendance, graduations, and degrees received.
7. Give all literary or scientific degrees you have received and names of institutions granting them, with dates.
8. With what languages or branches of science are you familiar?
9. When and where graduated in medicine?
10. When and where licensed to practice medicine?
11. Name principal medical societies of which you are a member. (Do not abbreviate.)
12. What specialty of medicine do you practice?
13. Proportion of time devoted to specialty?
14. Clinical experience in specialty? Institution? Number of years?
15. State all past hospital services. Hospital. Capacity. Date.
16. Present hospital connections. Hospital. Department. Capacity.
17. School and teaching positions occupied in the past. School. Capacity. Date.
18. School and teaching positions now occupied. School. Department. Capacity.
19. State all past experience in industrial or railroad medicine and surgery. Name and address of plant. Type of service (whether medical, surgical, occupational diseases, accident work, contract practice for families of workmen, etc.) Duration of service.
20. State all present connections with

industries or railroads. Name and address of plant. Type of service (whether medical, surgical, occupational diseases, accident work, contract practice for families of workmen, etc.) Time devoted to each plant.

21. State military, naval or public health experience you have had.

22. Are you a federal, state, county, or municipal officer? State exact designation of your office.)

23. Are you engaged in enterprises other than medicine? If so, what?

24. Have you followed any occupation, medical or otherwise, not already noted?

25. Have you previously been an applicant for entry into the United States Service? Service. When. Where. Result. (If rejected, state why.)

26. I have not applied for appointment in the Medical Reserve Corps of the Army, the Naval Reserve Force, or the Public Health Service owing to—(Check reason):

a. Physical disability. (State disability in detail.)

b. Over age (55). (State age in years.)

c. Essential institutional need. Name of institution. Position. Name and address of chief executive.

d. Essential community need. Approximate population. Number of physicians now practicing in your community.

e. Essential to Health Department. Name of department. Position. Name and address of chief of department.

f. Essential to industries. Name of plant. Position. Name and address of chief executive.

g. Essential to medical school. Name of medical school. Position. Name and address of dean.

h. Essential to Local or Medical Advisory Boards. Name and address of Board. Position.

i. Dependents. Number of dependents, including self but not employees. What proportion of your income or that of your dependents is derived from sources other than the practice of your profession? Do other persons contribute to the support of your dependents? Have you or your dependents other immediate relatives who could provide support for your dependents?

j. Sex. (State your sex.)

k. Religious conviction, not a citizen, or other reasons. (State reason.)

27. Are you available for any of the following services:

a. Consultant. Medical service. Surgical service. Public health service. Special service—What?

b. Institutional. Laboratory. Administrative. Medical service. Surgical service. Special service—What?

c. Medical service for industries. Part time. Full time. Own community. Other communities. Kind of work

d. Local or Medical Advisory Boards.

e. Reclamation of registrants rejected for physical unfitness.

f. Service to needy families and dependents of enlisted men.

g. Sanitation.

h. Miscellaneous service.

28. Check the Governmental service in which you would prefer to serve, if selected:

a. Medical Reserve Corps of the Army.

b. Naval Reserve Force.

c. Public Health Service.

NOTE.—Wherever practicable, your preference will be given consideration. However, the exigencies of war may render it necessary to ask you to do service other than that indicated as your choice.

29. Personal references. (Name three, at least one physician.)

I hereby make application for membership in the Volunteer Medical Service Corps of the United States. I certify that, to the best of my knowledge and belief, the answers to the preceding questions are true and correct in every respect. I pledge myself to abide by the rules and regulations of the Corps; to apply for a commission in the Medical Reserve Corps of the Army, the Naval Reserve Force, or for appointment in the Public Health Service when called upon to do so by the Central

Governing Board; and to comply with any request for service made by the Central Governing Board.

(Signature) .....

(Present Post-office address) .....

An outline of the purpose and scope of the Volunteer Medical Service Corps, contained in the folder, is as follows:

Volunteer Medical Service Corps organization:

1. Provides means for obtaining quickly men and women for any service required.

2. Furnishes recommendations and necessary credentials to assure the best of medical service both military and civil.

3. Determines beyond question the attitude of the individual toward the war.

OBJECT OF CORPS.

1. Placing on record all medical men and women in the United States.

2. Aiding Army, Navy, and Public Health Service in supplying war medical needs.

3. Providing the best civilian medical service possible.

4. Giving recognition to all who record themselves in Army, Navy, Public Health activities, or civilian service.

WORKING PLANS.

All matters pertaining to the organization will be under the direction of a Central Governing Board, authorized by the Council of National Defense and approved by the President of the United States, and its affairs will be conducted from the general headquarters of the Volunteer Medical Corps at Washington, D. C., under the Council of National Defense.

OPERATING SYSTEM.

1. Central Governing Board of twenty-five.

2. Forty-nine state executive committees.

3. One representative in each country in every state.

NOTE.—(*a*) All men to be appointed to state and county committees preferably over 55. (*b*) Each state executive committee to consist of five in the smaller states and one additional number in each of the larger states in proportion to each 1,000 medical inhabitants (to be nominated by state committees, medical section, Council of National Defense, from among their own members.) (*c*) Each county of 50,000 population or under should have one representative. All counties having over 50,000 population should have one additional county representative for each 50,000 population or fraction thereof. All county representatives to be nominated by the state executive committee.

DUTIES.

Central Governing Board. — To receive and pass upon all appointments.

State Governing Boards. — To receive facts from county representatives and make recommendations to Central Governing Board.

County Representatives. — To submit facts to state committees according to advice from central governing board or state executive committees.

Under the reorganization, every legally qualified physician, man or woman, holding the degree of Doctor of Medicine from a legally chartered medical school, who is not now attached to the Government service, and without reference to age or physical disability, may apply for membership and be admitted if qualified; whereas, the original organization admitted only those who for various reasons were ineligible to membership in the Medical Reserve Corps. The organization will mobilize the medical profession in order to provide for the health needs of the military forces and the civil population, and the recording and classifying of doctors will afford means of obtaining quickly men and women for any service required.

To date about 40,000 of the 144,116 doctors in the United States—not including the more than 5,000 women doctors—either are in government service or have volunteered their services. Up to July 12 the Surgeon General had recommended to the Adjutant General 26,733 doctors for commissions in the Medical Reserve Corps. About 9,000 others who applied were rejected. With the 1,194 in the Medical Corps of the National Guard and 1,600 in the Navy, the total—38,527—constitutes

26,73 per cent of the civilian doctors. Deducting those who declined their commissions or who have been discharged because of subsequent physical disability or other cause, the number actually commissioned in the Medical Reserve Corps stands (August 23) at 23,531 with several hundred recommended whose commissions are pending. Of the 23,531 there are 22,232 now on active duty.

The need for using wisely the service of the medical men, in view of the universal war activities, is indicated when it is known that in the five weeks ended August 2 there were 2,700 medical officers commissioned in the Army, Navy, and Public Health Service—or at the rate of 540 per week. This rate at which enrollment is proceeding is the cumulative result of the operation of all the machinery which has been in process of setting up since the United States entered the world war. While the number commissioned in the five weeks mentioned may seem large, it is not much greater than the rate at which medical men have been receiving their commissions during the past year. There are now 28,674 medical officers commissioned in the three services—26,027 in the Army, 2,427 in the Navy, and 220 with the commission of Assistant Surgeon in the United States Public Health Service. Of the 2,700 commissioned in the five weeks ended August 2, there were 2,527 in the Army, 169 in the Navy, and four in the United States Public Health Service. Also forty doctors designated as Acting Assistant Surgeons have been taken on in the Public Health Service in the last two months, twenty-one for work in extra-cantonment zones, fourteen for special venereal disease work, and five for marine hospitals. The 26,027 in the Army medical service comprise 933 in the Medical Corps, the regular Army service; 23,531 in the Medical Reserve Corps; 1,194 in the Medical Corps of the National Guard, and 369 in the Medical Corps of the National Army.

It is estimated that at least 50,000 doctors will be necessary eventually for the Army. It can readily be seen that with the enrollment of these active men, their places in communities and institutions must be cared for and the work, therefore, throughout the country must be so systematized and co-ordinated that the civilian population may not suffer. An important aspect is the need for medical men in the communities where munitions and other vital war products are being made.

The Volunteer Medical Service Corps, supervised by the Central Governing Board now named, will thoroughly care for these needs.

In connection with the mailing of membership blanks for the Volunteer Medical Service Corps to all legally qualified men and women doctors of the country, Dr. Franklin Martin, chairman of the General Medical Board of the Council of National Defense, says:

"Great as has been the response to the appeal for doctors, it must be greater. It is imperative that every doctor not already in a government service fill out, sign and return the blank to the offices of the Central Governing Board, Council of National Defense, Washington, at once. We believe thousands will do this, as they are anxious to be enrolled as volunteers for the Medical Departments of the Army and Navy before registration under the new draft law goes into effect. The appeal for enrollment in the Volunteer Medical Service Corps, which President Wilson has formally approved, is an official governmental call to service. This will place the members of the medical profession of the United States on record as volunteers, available for classification and ready for service when the call comes."

Yeast in the Treatment of Acne.

As already stated, the importance of bakers' yeast in the treatment of acne vulgaris was pointed out by Hawk and collaborators (loc. cit.), who used it with success in a variety of conditions. Brewers' yeast had for a long time been used with success in the treatment of acne. It possesses, however, the disadvantages of

non-availability and non-uniformity. Hawk treated seventeen cases of acne vulgaris with one to three cakes of baker's yeast daily. Many of these cases had resisted other treatment. In from one week to two months all the cases of acne vulgaris had improved or were cured. Hawk states: "Whether the success of yeast in acne vulgaris and acne rosacea is due alone to its laxative action or to some fixed effect on the intestinal tract we are unable to say. The preparation was laxative in all these cases. We consider that yeast is fully as successful as any other remedy in furunculosis, acne vulgaris and acne rosacea."

As stated, yeast has been used at various times in the treatment of acne, and with success. There seems to have been a prejudice in favor of brewers' yeast, but this the article by Hawk should remove.

Among the medical authors who have used yeast with success in acne are Saalfeld (Deutsche Med. Wochenschr, V. XXXII, No. 29; July 19, 1906, p. 1163) and Paschkis (Wiener klin. Wochenschr, V. XV, No. 31; July 31, 1902, p. 791). Saalfeld noticed a diminution of the indican in the urine of his patients, or even its disappearance, under yeast treatment. The possibility of the diminution of blood-sugar is to be thought of. Paschkis employed both brewer's yeast and baker's yeast with good effect.

The value of yeast in acne is freely acknowledged in the text books. Thus, yeast or its preparations is recommended in the text books of Darier (1909), Walsh (1913), Sibley (1916), and Gougerot (1917). Chatelain (1910) has used bakers' yeast in acne without seeing a great difference between the results of brewer's yeast and baker's yeast.

Acne due to chemicals should be treated by the removal of the cause.

———R———

Assistant Physician U. S. Penitentiary.

The Journal of the Kansas Medical Society:

The Department of Justice has authorized me to employ an assistant physician for the United States Penitentiary, Leavenworth, Kansas, at an annual compensation of fifteen hundred dollars and quarters with board. The applicant must be graduated from a reputable medical school, of good character and temperate.

This position will require presence on the ground at night and such portion of the day as the Warden may see fit.

Applications for this position must be made in person to the Warden of the Institution and the applicant must at the same time present his credentials.

Believing this may be of use to your profession, I request that you give it publicity. Respectfully,

THOS. W. MORGAN, Warden.

———R———

County Representatives, Volunteer Medical Corps in Kansas

Appointment of county representatives in Kansas to handle locally the work of the central governing board of the volunteer medical service corps has been announced by the National Council of Defense. The Kansas state executive committee, announced some time ago, is composed of Dr. S. J. Crumbine, Topeka; Dr. George M. Gray, Kansas City; Dr. J. F. Axtell, Newton; Dr. Charles S. Huffman, adjutant general, Topeka; Dr. Samuel Murdock, Jr., Sabetha; Dr. Joseph E. Sawtell, Kansas City; Dr. David W. Basham, Wichita. The purpose of this committee is to co-operate with the central governing board in prosecuting all activities pertaining to the mobilization and enrollment of members in the corps throughout the state.

The county representatives are:

Allen—Dr. R. N. McMillen, Iola.
Anderson—Dr. J. A. Milligan, Garnett.
Atchison—Dr. E. T. Shelly, Atchison.
Barber—Dr. H. Gilbert, Medicine Lodge.
Barton—Dr. E. E. Morrison, Great Bend.
Bourbon—Dr. Van Velzer, Fort Scott.
Brown—Dr. L. Reynolds, Horton.
Butler—Dr. F. A. Garvin, Augusta.
Chase—Dr. J. F. Shelly, Elmdale.
Chautauqua—Dr. L. D. Tout, Cedarvale.
Cherokee—Dr. R. B. English, Columbus.
Cheyenne—Dr. B. F. Jeffres, St. Francis.
Clark—Dr. W. F. Taylor, Ashland.
Clay—Dr. G. W. Bale, Clay Center.
Cloud—Dr. S. C. Pigman, Concordia.
Coffey—Dr. J. C. Fear, Waverly.
Comanche—Dr. M. R. McCroskie, Wetmore.
Cowley—Dr. H. L. Snyder, Winfield.
Crawford—Dr. D. O. Munson, Pittsburg.

Decatur—Dr. L. C. Tilden, Oberlin.
Dickinson—Dr. J. N. Deiter, Abilene.
Doniphan—Dr. Wm. M. Boone, Highland.
Douglas—Dr. W. C. McConnell, Lawrence.
Edwards—Dr. C. A. Boyd, Belpre.
Elk—Dr. F. L. DePew, Howard.
Ellis—Dr. F. K. Meade, Hays.
Ellsworth—Dr. Alfred O'Donnell, Ellsworth.
Finney—Dr. Wm. J. Stilson, Garden City.
Ford—Dr. C. E. McCarty, Dodge City.
Franklin—Dr. H. L. Kennedy, Ottawa.
Geary—Dr. W. A. Smiley, Junction City.
Gove—Dr. J. H. McNaughton, Gove City.
Graham—Dr. I. B. Parker, Hill City.
Grant—Dr. G. R. Hickok, Satanta.
Gray—Dr. G. W. Hollenbeak, Cimarron.
Greenwood—Dr. W. T. Grove, Eureka.
Hamilton—Dr. Chas. F. Harrison, Syracuse.
Harper—Dr. A. E. Walker, Anthony.
Harvey—Dr. Max Miller, Newton.
Haskell—Dr. L. V. Miner, Santa Fe.
Hodgeman—Dr. John F. McDonald, Jetmore.
Jackson—Dr. E. W. Reed, Holton.
Jewell—Dr. E. L. Raynolds, Mankato.
Johnson—Dr. F. F. Green, Olathe.
Kearney—Dr. G. F. Johnson, Lakin.
Kingman—Dr. B. H. Pope, Kingman.
Kiowa—Dr. P. F. Wesley, Haviland.
Labette—Dr. G. W. Gabriel, Parsons.
Leavenworth—Dr. J. L. Everhardy, Leavenworth.
Lincoln—Dr. Otto Dierker, Sylvan Grove.
Linn—Dr. T. W. Warner, Parker.
Logan—Dr. C. C. Winslow, Oakley.
Lyon—Dr. C. S. Trimble, Emporia.
Marion—Dr. B. T. Prather, Peabody.
Marshall—Dr. Wm. D. Patterson, Marysville.
McPherson—Dr. J. G. Hall, McPherson.
Meade—Dr. C. B. Leslie, Meade.
Miami—Dr. Melton, Hillsdale.
Mitchell—Dr. W. H. Cook, Beloit.
Montgomery—Dr. A. E. Miner, Independence.
Morris—Dr. J. A. Woodmansee, Dunlap.
Morton—Dr. W. V. Tucker, Elkhart.
Nemaha—Dr. Willard A. Haynes, Sabetha.
Neosho—Dr. A. N. Davis, Chanute.
Norton—Dr. W. C. Lathrop, Norton.
Osage—Dr. F. F. Schenk, Burlingame.
Osborne—Dr. B. F. Chilcott, Osborne.
Ottawa—Dr. G. E. Ganoung, Minneapolis.
Pawnee—Dr. L. R. Sellers, Larned.
Phillips—Dr. A. E. Nelson, Phillipsburg.
Pratt—Dr. O. F. Searle, Bellevue; Dr. H. W. Walker, Pratt.
Rawlins—Dr. W. C. McIrwin, Atwood.
Reno—Dr. C. Klippel, Hutchinson.
Republic—Dr. C. M. Arbuthnot, Belleville.
Rice—Dr. M. L. McCrea, Sterling.
Riley—Dr. Geo. H. Ross, Manhattan.
Rooks—Dr. W. B. Callender, Stockton.
Russell—Dr. R. A. Stewart, Russell.
Saline—Dr. W. E. Mowery, Salina.
Sedgwick—Dr. H. H. Taggart, Wichita.
Seward—Dr. W. F. Huddleson, Liberal.
Shawnee—Dr. W. E. McVey, Topeka.
Sheridan—Dr. E. D. Beckner, Hoxie.
Sherman—Dr. W. H. Smith, Goodland.
Smith—Dr. C. C. Funk, Smith Center.
Stafford—Dr. J. T. Scott, St. John.
Stanton—Dr. W. F. Hoover, Johnson.
Stevens—Dr. W. E. Bundy, Hugoton.
Sumner—Dr. S. T. Shelly, Mulvane.
Thomas—Dr. V. C. Eddy, Colby.
Trego—Dr. W. Y. Herrick, Wakeeney.
Wabaunsee—Dr. J. C. Bennett, Eskridge.
Wallace—Dr. W. W. Carter, Sharon Springs.
Washington—Dr. Wm. M. Earnest, Washington.
Wilson—Dr. A. G. Flack, Fredonia.
Woodson—Dr. H. W. West, Yates Center.
Wyandotte—Dr. L. F. Barney, Kansas City.

To the Army and Navy.

The following physicians of Kansas have been reported as having accepted commissions in the army and navy since August 1:

C. E. Boudreau, Eldorado
A. E. Billings, Topeka
F. H. Slayton, Wichita
O. J. Corbett, Emporia
H. T. Davidson, Wichita
H. R. Scates, Baxter Sp'gs
C. W. Demott, Independ'ce
R. O. Preston, Meriden
R. H. Downing, Wellington
W. F. Neinstedt, Hartford
A. B. Ingels, Larned
J. A. Settle, Reading
J. C. Caldwell, Wellington
R. S. C. Fisher, Wichita
O. K. Haydon, Elk City—Navy.
D. Peterson, Latham
L. S. Coplan, Wellington
L. R. McKeehan, Atchison
J. W. Cheney, Wichita
E. D. Ebright, Wichita
J. O. Williams, Emporia
V. H. Bantleon, Kansas City
L. V. Sams, Topeka
A. J. O'Leary, Burr Oak
G. R. Gage, Hutchinson
H. G. Hunsberger, Mt. Hope
N. D. Miller, Topeka
T. M. Agnew, Wichita

Orders to Officers of the Medical Reserve Corps in Kansas.

Lieut. C. E. Shepard, Baldwin City, to Camp Crane, Allentown, Pa., base hospital, from New York. Lieut. C. E. Yates, Vinland, for duty, from Camp Travis.

Capt. C. H. Koontz, Onaga, to Camp Grant, Rockford, Ill., for duty, from Fort Riley. Lieut. J. L. Peppers, Newton.

Capt. G. I. Thacher, Waterville, to Camp Jackson, Columbia, S. C., base hospital, from Camp Crane.

Lieut. J. C. McKinnon, Caldwell, to Camp Kearney, Linda Vista, Calif., for duty, from Portland, Ore.

Major J. D. Riddell, Salina, to Camp Las Casas, San Juan, P. R., base hospital, from Fort Riley.

Lieut. J. A. H. Webb, Stafford, to Camp Lee, Petersburg, Va., base hospital, from New York.

Capt. F. T. Johnson, Jr., Elmdale, to Camp McClellan, Anniston, Ala., for duty, from Camp Upton.

Lieut. C. W. Hall, Hutchinson, to Camp Sherman, Chillicothe, Ohio, base hospital, from Camp Dix.

Lieut. J. M. Marks, Valley Falls, to Camp Upton, L. I., N. Y., base hospital, from Fort Oglethorpe.

Lieut. F. B. Sheldon, Manhattan, to Camp Wadsworth, Spartanburg, S. C., base hospital, from New York.

Lieut. E. J. Frost, Wichita, to Fort Oglethorpe, from New York. Lieut. M. F. Russell, Great Bend, for instruction.

Lieut. T. M. Aknew, Wichita, to New Haven, Conn., Yale Army Laboratory School, for instruction.

Capts. A. A. Shelley, Galena; J. W. Nixon, Girard; G. R. Gage, Hutchinson; E. A. Reeves, Kansas City; H. G. Hunsberger, Mount Hope; C. L. Randall, Neodesha; A. E. Billings, Topeka; J. C. Caldwell, W. M. Martin, Wellington; Lieuts. D. Peterson, Atlanta; W. J. Lowis, Colby; A. J. Turner, Garnett; W. S. Hudiberg, Independence; C. W. Longenecker, Kingman; W. B. Burr, Longton; E. C. Lightfoot, Mineral; H. A. Vincent, Perth; W. V. Hartman, Pittsburg; H. T. Davidson, Wichita, all to Fort Riley for instruction.

Capt. B. H. Jordan, Medicine Lodge, to report to the commanding general, Central Department, for assignment to duty.

Capt. John F. Rudolph, Belle Plaine, to Camp Abraham Eustis, Lee Hall, Va., camp hospital, from Camp Lee.

Lieut. John R. Campbell, Coats, to Camp Beaure-

sult of their treatment of furunculosis and other skin conditions with compressed yeast (Fleischmann's). The use of fresh bakers' yeast brought about an improvement or cure in sixteen of seventeen cases of furunculosis, as well as in a case of folliculitis, and in other skin conditions. The cases were followed up weeks to months, after cessation of treatment, without recurrence of furunculosis. One of the cases had previously been treated with vaccines. Fleischmann's Compressed Yeast may be taken in water, beef tea, or orange juice, and there is no reason why it could not be administered spread on bread. The doses usually administered were one-half to one cake three times daily. Some of these patients had been suffering with boils for a long period of time. Usually the cases were cured or boils considerably improved within two weeks after the administration of the first dose. Sometimes, because of gas formation in the gastro-intestinal tract, it was necessary to kill the yeast cells just before administration by immersing the cake for a few minutes in boiling water.

Hawk concludes that "bakers' yeast was found to be a useful remedy in the treatment of furunculosis, acne vulgaris, acne rosacea, constipation, and in certain other cutaneous and gastro-intestinal conditions."

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The Illegitimate Baby's Rights.

The rights of illegitimate children and the State's responsibility for seeing that every child, no matter what his parentage, has the nurture, protection, and education essential to his usefulness as a citizen are for the first time given complete national recognition in the Norwegian laws concerning illegitimate children, according to a report issued by the Children's Bureau of the U. S. Department of Labor.

These laws make the State instead of the mother responsible for establishing paternity. The State holds both parents equally and continuously responsible for the illegitimate child—"The child shall be entitled to bringing up — maintenance, training, and education — from both its father and its mother." The report contains a translation of the several Norwegian laws, with amendments, on illegitimate children and their care. A history of the efforts through which the legislation was secured is given in the introduction.

The attitude which looks upon illegitimacy as a child-welfare problem that must be solved for the sake of the child and of the State is exemplified by this Norwegian legislation. In connection with its studies of the bearing of the war upon child welfare the Children's Bureau examined the evidence obtainable but could not find that it justified the statements that have been circulated of widespread increase in illegitimacy since the war. The Bureau believes, however, that the needs of the illegitimate child must be considered in the Children's Year campaign "to save 100,000 children's lives during the second year of the war and to get a square deal for children." In the Children's Year Working Program attention is called to the necessity of providing opportunity for normal development to the child of unmarried parents.

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Dependability of Tablets.

There is no doubt about the convenience of tablets, but the accuracy of the dosage content is not always to be depended on. In 1914 Kebler reported the results of a far-reaching investigation of tablet compounding in which he pointed out that tablets on the market were not as uniform or accurate as was generally believed. During the past year the Connecticut Agricultural Experiment Station undertook the examination of tablets—proprietary and nonproprietary—taken from the stock of dispensing physicians. The variations found in weights of the tablets were strikingly similar to those reported by Kebler.

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rollment for the Medical Reserve Corps of the Army and the Reserve Force of the Navy which is going on so rapidly at the present time, shall not be interrupted. Trusting that you will give this prominent space in the next issue of your Journal and such editorial comment as you may deem desirable, I am,

Yours very truly,

FRANKLIN MARTIN,

Chairman, General Medical Board.

Deaths.

Lieut. Col. Clarence Leroy Cole, M.C., U. S. Army, San Antonio, Texas, Medical College, Topeka, 1903; aged 41; a Fellow of the American Medical Association; who entered the Army, May 10, 1905, and was in charge of the laboratory at Fort Sam Houston, Texas; who recently had been under treatment at the Walter Reed Hospital, Washington, D. C.; was found dead in his quarters, August 9, from a bullet wound of the head, self inflicted, it is believed with suicidal intent, while suffering from mental depression.

Lieut. Guy Augtin Tull, M.R.C., U.S. Army, Kansas City, Mo.; on duty with the Three Hundred and Fifty-Third Infantry, Camp Funston, Kans.; Kansas Medical College, Topeka, 1895; aged 49; a Fellow of the American Medical Association; and of the American Academy of Medicine; once president of the Clay County (Kansas) Medical Society and surgeon for the Rock Island System; died at his home, July 13, from chronic interstitial nephritis.

Andrew Pearson, Wakefield, Kan., Rush Medical College, 1883; resident physician at the Chiloco Indian Reservation; died in the Presbyterian Hospital, Chicago, July 14.

Mary Dugan Ardery, Garden City, Kan.; Keokuk (Iowa) Medical College, 1891; aged 76; formerly a member of the Kansas Medical Society; who retired from practice several years ago on account of paralysis; died at the home of her daughter in Garden City, July 23.

The Health Officer and the Big Fight.

It is said to take nine men working "over here" to keep one soldier fighting "over there." Clearly, therefore, it is wise to keep the nine workers husky and working as well as the one soldier.

Which health officer should stay at home and who should go to war? How is the nation bearing up under the war strain? What are the special war-time health menaces of the civil population, and what are we going to do about them? What headway are we making against the venereal diseases? These are the questions to be considered at the convention of United States and Canadian sanitarians at Chicago, October 14-17, to be held under the auspices of the American Public Health Association. Some of the military sanitarians who will address the meetings are Surgeon General Gorgas, Colonel Victor C. Vaughan, and Major William H. Welch of the Army Medical Corps. Other speakers at the general sessions will be George H. Vincent, president of the Rockefeller Foundation, Dr. Charles J. Hastings, president of the American Public Health Association, Dr. W. A. Evans, Assistant Surgeon General Allan J. McLaughlin, U.S.P.H.S., Dr. Ernest S. Bishop, Dr. Lee K. Frankel, Dr. Frederick L. Hoffman and others.

As the health of the civil population has a direct bearing upon the winning of the war, mayors and governors are being requested to send their health officers to the conference in spite of the present high cost of government.

The final program will appear in the American Journal of Public Health appearing September 25. For further information write to A. W. Hedrich, Secretary, American Public Health Association, 1041 Boylston St., Boston, Mass.

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THE JOURNAL
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Kansas Medical Society

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Report of an Unusual Case of Foreign Body in Abdomen.

ALFRED O'DONNELL, M.D., Ellsworth, Kansas.

Read at the Fifty-second Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

C. K., age 27, male, carpenter, single, Kanopolis, Kansas. Admitted July 3, 1916. Chief complaint, foreign body in the rectum.

Past History—Measles, mumps, chickenpox when a child, had typhoid fever at the age of three, always strong and healthy. August 2, 1915, while in a hay loft fixing a hay carrier on the track, the carrier became loose and he fell about twenty-five feet, alighting on his feet and then on his buttocks. At once he became partially paralyzed from his waist down. Following this accident he had complete retention of feces and urine. He was taken to the hospital six days later and stayed six weeks, being in bed five weeks. He was able to walk fairly well but had to take a strong cathartic to move his bowels and catheterize himself for six months following. Previous to this recent injury he was quite steady on his feet and was delivering ice.

Family History—Mother died, age 64, with goiter. Father 69, living and well. Six brothers alive and well. Three sisters alive and well.

Physical Examination — Patient intelligent and well nourished and no muscular atrophy or loss of strength.

History of Complaint—July 2 at 10 P.M. while in his bed room he was using a large red, white and blue souvenir lead pencil, 12 inches long, "to doctor his piles." He covered the round smooth cap end with mentholatum and in a standing posture inserted it into the rectum four or five inches, which had been his custom for five or six years. Just previous to this operation he had swallowed a small piece of cigar which he had been smoking and noticed that he had felt sick on his way upstairs to his room. Soon after he had inserted the lead pencil he became dizzy and fell backwards, falling quite forcibly on the bed and driving the pencil so far up into the rectum that he could not touch it. The proximal end was sharpened quite bluntly but caught into one of the rectal folds so that it could not be retracted. He became quite sick after this and vomited several times. He suffered considerable pain, but this was probably not so severe on account of an injury to his back which he received August 2, 1915, and which left him partially paralyzed. Dr. Reitzel of Kanopolis was called that night but was unable to remove the pencil in spite of the relaxed and almost insensitive condition of the rectum and sphincters. He brought the patient to the Ellsworth Hospital at 11 A.M. July 3, temperature 100.8, pulse 100, and some marked abdominal distention.

At 1:30 P.M. he was taken to the operating room and attempts were made to remove the pencil per rectum without success. The point seemed to be imbedded in the mucous membrane and completely in the abdominal cavity.

Operation: Incision made in the ab-

dominal wall in medium line reaching up into the umbilicus. On opening the abdomen free purulent fluid was found, distended coils of the bowel protruded through the incision and it was not possible to continue exploration of the abdomen until a distended coil was opened and emptied of gas and contents. The foreign body was found lying in the right half of the abdomen, the upper end resting under the border of the liver and the lower end down in the pelvis, having broken through the pelvic colon. It was found impossible to remove the pencil without enlarging the incision upward. This was done and the pencil removed. The intestinal coils which had been out were returned to the abdomen after being washed off with warm salt solution. No attempt was made to close the wound in the rectum. A liberal gauze drain was inserted in the pelvis down to the wound in the rectum, wound was closed with the exception of the lower two inches which was left for drainage. Patient made uneventful recovery, left hospital in two weeks and in one month was down town.

After the removal of the foreign body the treatment of this case resolved itself into the treatment of the peritonitis which had begun to develop.

Deaver and Peiffer[1] give the following points:

"The prognosis of peritonitis is influenced chiefly by (1) the type and degree of the infection; (2) the situation of the infection; (3) the time of operation; (4) the operation itself; (5) the pre-operative treatment; (6) the post-operative treatment."

It is impossible to lay down a general rule in all cases, but it may be said that it is seldom possible to act too quickly in peritonitis caused by the appendix or by a perforated gastric or duodenal ulcer, while in peritonitis of pelvic origin delay should be the rule. Peritonitis of rapid spreading character seldom comes from the gall bladder, when present it is usually due to perforation and demands quick action. Another important rule in the presence of actual peritonitis is to do the least that is consistent with the ends of the operation and in the shortest time compatible with good work. There is one exception to this rule, that is the performance of a gastroesterostomy at the same time as the closure of a perforated gastric or duodenal ulcer. As to the post-operative treatment the slogan should be, let him get well.

If the operation is performed early and well done there will be little to do and the less done the better. The sharp watch must be kept for complications and symptomatic treatment given for individual conditions as they may arise. The sitting posture, Murphy drip, nothing by mouth and careful nursing are important factors. Water, hot or cold, is used when peristalsis begins, as is shown in the passage of gas or staining of the fluid in the Murphy drip reservoir. Nausea, vomiting and persistent regurgitation and marked distention of the upper abdomen calls for the use of the stomach tube.

[1]N. Y. Med. Jour., CII 977; Deaver, J. B., and Peiffer, D. B.

First Aid to the Neurotic.

MAUD S. DELAND, M.D., State Hospital, Topeka.

Read at the Fifty-second Annual Meeting of the Kansas Medical Society held at Kansas City, Kansas, May 1, 2 and 3, 1918.

As it is of the greatest importance that the first aid to those injured in battle should be of the proper kind, so it is also important that the first aid to those injured in the mental conflicts of life should be a sympathetic understanding of the difficulties that beset the individual, and not a fanatical attempt to mould him to our own particular beliefs. He has already been trying to adapt himself to his environment and failed in the attempt. He cannot pull himself up by his own bootstraps, and we must help him to understand his difficulties and supply him with new motives.

The patients who reach the state hospitals almost invariably present a well-developed and often intractible psychosis. And it is conceded that it is impossible to

do psychoanalysis in imbeciles, dements, seniles or organic cases, in acute maniacal or catatonic excitement and in mute patients. Thus comparatively few cases in state hospitals are subjects for psychoanalysis. It is the general practitioner who gets the cases of hysteria, obsessional and anxiety neuroses, the paranoid conditions and the early dementia praecox cases.

This afternoon I am here not to try to convince you of the value of the Freudian theories, for I have already given you the reasons why I believe in them in a paper published in the Journal of the Kansas Medical Society, but I am here simply and solely to plead with you to investigate the mental life of your patients as carefully as you investigate physical symptoms and to co-operate with the doctors who are making a specialty of mental diseases in order that we may all arrive at the truth. Or if you do not wish to take the time to study and apply psychoanalysis for yourselves at least refer your patients to one making a specialty of this work before they present a well-developed psychosis.

What perhaps all of us desire most is to understand human beings as biological units. One may specialize on gall bladders, stomachs, noses or brains, but this knowledge is most valuable when co-ordinated. It would be well for us to know whether a larger number than normal of the insane suffer from kidney disease or intestinal stasis, but it is just as important to know what mental state attends diseases of the liver or thyroid or heart or lungs. Is there, or is there not, any correlation between mental and physical states? If there is, what is it? If not, what do our mental states result from? As Luther Burbank says: "A knowledge of the battle of tendencies within the plant is the very basis of all plant improvement. It is not that the work of plant improvement brings with it, incidentally, as people mistakenly think, a knowledge of these forces, it is a knowledge of these forces rather which makes plant improvement possible." This is equally true of people. And perhaps if we physicians understood people as well as Luther Burbank understands plants, there might be more improvement in the human race. The teacher may instruct along certain lines, the preacher may preach what he has been taught to believe, and the lawyer may argue from precedent, but it is we physicians who should know not only the livers and stomachs of our patients, but their thoughts and feelings and desires. But we can never know them until we ourselves are able to lay aside all critique, all ideas of what the patient should or should not have done, and investigate the mental life of the patient in an unprejudiced and unemotional manner as we do the appendix.

Equally necessary is the realization that with the patient's heredity and environment, he *could not* be otherwise than what he is. As Burgson so beautifully puts it: "Our duration is not merely one instant replacing another. Duration is the continuous progress of the past, which gnaws in the future and which swells as it advances. The past follows us at every instant; all that we have felt, thought, and willed from our *earliest infancy* is there, leaning over the present which is about to join it, pressing against the portals of consciousness that would fain leave it outside. The cerebral mechanism is arranged just so as to drive back into the unconscious almost the whole of the past, and to admit beyond the threshold only that which can cast light on the present situation or further the action now being prepared. In short, only that which can give *useful* work. At the most, a few superfluous recollections may succeed in smuggling themselves through the half-open door. These memories, messengers from the unconscious, remind us dimly of what we are dragging behind us unawares. But even though we may have no distinct idea of it, we feel vaguely that our past remains present to us. What are we in fact, what is our character, if not the condensation of the history we have lived from our birth—nay, even before our birth—since we bring with us prenatal dispositions?

Doubtless we think of only a small part of our past, but it is with our entire past, including the original bent of our soul, that we desire, will, and act. Out past, then, as a whole, is made manifest to us in its impulse; it is felt in the form of tendency, although a small part of it only is known in the form of the idea."

Another essential to the understanding of the mental life is that man shares with the animals the instinctive trends of procreation and self-preservation and that, as Jung says: "Nature has the first claim on man; only long afterwards does the luxury of intellect come. In our present social conditions the nutritional striving is allowed normal gratification and occasions no trouble. To the instinct of procreation, not only in its strictly sexual meaning but in its transformation into creative energy which is used for mechanisms for allurement and protection of the young and the expression of emotions, Freud has given the name libido. With him it is practically synonymous with our word love." Jung has still broadened this conception until with him the word libido signifies that energy which manifests itself by vital processes and is subjectively perceived as aspiration, longing and striving. And he further states, "It can be a surprise only to those to whom the history of evolution is unknown to find how few things there really are in human life which cannot be reduced in the last analysis to the instinct of procreation. It includes nearly everything, I think, which is beloved and dear to us."

Our present social system demands the suppression of the normal manifestations of the sexual libido both in childhood and the adult, except under certain prescribed regulations. In many cases this suppression is most cruelly and stupidly administered. The child misunderstands its purpose, and is frightened and made to believe itself a great sinner. The conflict between the instinctive trends and the repressing forces causes much mental anguish, and is therefore repressed into the unconsciousness. If this repression is successful the libido is sublimated in the external world of reality. But often these instinctive trends break through the repression and appear in a disguised form. This is especially true at the time the individual develops into manhood or womanhood and has to make new adaptations in life. While Freud lays more stress on the character of the conflicts and repressions of childhood, and the influences of the parents, Jung, while not minimizing these facts, places the cause in the present moment. That is, "The conflict is produced by some important task or duty which is essential biologically and practically for the fulfillment of the ego of the individual, but before which an obstacle arises from which he shrinks, and thus halted cannot go on." Perhaps there is not so much difference in these two views after all, as if the childhood had been different the individual might have met the present condition; and if the present condition had not developed, the childish predisposition would not have produced the illness. But be that as it may, in hysteria this repressed libido is converted into physical symptoms. In the obsessional neuroses it returns in a disguised form such as hypochondriacal, social, or religious anxiety or as various phobias, superstitions, or dipsomania. In dementia praecox this libido is introverted —the patient withdraws from reality.

To again quite Jung, "Just as the normal libido is comparable to a steady stream which pours its water broadly into the world of reality, so the resistance dynamically considered is comparable, not so much to a rock rearing up in the river bed which is flooded over or surrounded by the stream, as a backward flow towards the source. A part of the soul desires the outer object; another part, however, harks back to the subjective world, where the airy and fragile palaces of phantasy beckon." In other words when the libido encounters internal conflict and is repressed, it seeks expression, either through less fundamental trends, as when one disappointed in love takes to religion, or else through a symptom in a neurosis, or goes

back to an infantile manifestation of the original trend and becomes auto-erotic. In other words the libido becomes retrogressive in its manifestations. When plants or animals revert back to primitive forms, we call it atavism; when the libido of an adult expresses itself in an infantile manner we call it regression. This tendency towards regression is not confined to a neurosis or a psychosis. It is present in us all. We long for ease and indolence and old forms, and fear to try that which is new.

When the individual is unable to make new adaptations, there is often present what is called the Oedipus or incest complex. To the strictly literal mind which can grasp this old Grecian myth only in its concrete form, it means that the boy killed his father and married his mother, but the psychological truth, as expressed by Jung, is that the fundamental basis of incestuous desire does not aim at cohabitation, but at the special thought of becoming a child again, of turning back to the parent's protection, of coming into the mother once more in order to be born again.

Freud's idea of the Oedipus complex is perhaps more practical, and we must remember that in this we are dealing with the unconscious and not the conscious life. At first the child is only interested in his own body, is auto-erotic. Then his interest and attachment become greatest for his food-giving and comfort-giving mother. Then the biological trend is followed out and the child's libido is directed toward the parent of the opposite sex. Then as the child grows up, the incest prohibition and social conditions force it to seek the love object outside the family. "Thus the Oedipus complex becomes a measuring rod to determine the grade of evolution of psychological activities looking forward to ultimate social values. The analysis of one's acts shows how far in the scheme of evolution the particular act may be placed, whether it remains an infantile fantasy way of obtaining satisfaction from the father-mother attachment or rejection (according to sex) or a grown-up sublimation way which is socially, and hence individually, valuable." (Jelliffe.) Identically the same energy is utilized, but one is valuable, the other wasted. "In our neurotics we find that when life presents an insurmountable obstacle and they are driven back from the pathway that leads into reality, they regressively reanimate the old pathway of least resistance and seek infantile ways of obtaining pleasure. Our patients give us all sorts of examples of their attachment to past infantile dependence on their parents and thus seek to avoid the burdens imposed by reality. Or again they may live only in dreams of the future and project their infantilism into Paradise." Anything to shirk the responsibilities of the present.

Now on the basis that the past is always with us, that conflict causes repression into the unconscious, that the repressed libido in a disguised or distorted form is causing symptoms, the practical problem is simply one of unearthing the buried complexes and freeing the libido attached to them, so that it can be projected in full consciousness into the world of reality. This cannot be done by simply gaining the confidence of the patient and getting him to tell all he knows, for the trouble is inaccessible to him. If he knew he would cure himself. Freud first tried hypnotism as a means for tapping the unconsciousness, but found that this could be better done and was available in more cases by a method which he termed Psychoanalysis. Now the postulate on which psychoanalysis is based is that "every idea has a basis which is as absolutely determined as any other reality of nature."

All the history that the patient can give is obtained, especially his family and early history, for the family is the child's first training camp, father and mother are at first his sole source of authority and comfort. Then various questions relating to traits, habits, sociability, etc., are asked. All the patient's little habits and mannerisms are noticed, all his little ceremonials as expressed in every-day conduct, for per-

sistent habits are often an infantile manner of obtaining satisfaction at least in fantasy.

When confidence in the physician is established, the patient is placed in a position to be as free from distracting influences as possible, is asked to relax and with an utter absence of all critique, utter freely all thoughts which come to him in connection with his troubles, his childhood or in whatever line the physician sees fit to direct. One of the most important sources of gaining information of the unconscious is through dreams. The patient is asked to tell his dreams or write them out. Then by a method of free association there will be found beneath the manifest content of the dream its latent content. This gives an important clue to what is going on in the patient's mind during the analysis. It is to be particularly noted that there is no meaning in dreams in the sense of the old superstition that to dream of a certain thing has a definite meaning. There is no meaning to anything in the dream until it is brought out by associations in the mind of the dreamer. A pond of water may mean one thing to one person and another thing to another, the meaning is only determined by the particular life and experiences and therefore associations of the dreamer.

Of course the foregoing all sounds very simple, but let not any one be misled into believing that psychoanalysis is a simple or easy thing. It takes more time and patience and hard work to acquire than a surgical technique for we are dependent on the whims and moods of the patient, and have to deal with the very practical problems of resistances, transferences, etc., all of which I have not touched on. For it can easily be seen that if the resistance was great enough to drive the conflict from the consciousness of the patient, and not allow it to be recognized in the symptoms, that resistance is still at work, and can only be overcome by much hard work and patience.

Do not think that psychoanalysis is something applicable only to the neurotic. It is applicable to us all, and were we to submit to a psychoanalysis, and be honest in it, we would all be astonished at ourselves. We would have to get acquainted with ourselves all over again, for there we would find the basis of many of our prejudices which we fondly call principles, our likes and dislikes, tastes and inclinations. Also we would detect the real basis of our opposition to the Freudian psychology and our disbelief in psychoanalysis. The result of digging down into the hidden psyche has brought to light the fact that "he who remains healthy has to struggle with the same complexes which cause the neurotic to fall ill." It is psychoanalysis which furnishes us a key to the understanding of human conduct.

———R———

Clinical Eponymic Signs.

(Continued from Page 223)

REICHMAN'S SIGN—The presence in the stomach before eating in the morning, of an acid liquid mixed with alimentary residues; it is indicative of gastrosuccorrhea and pyloric stenosis.

REMAK'S SIGN—The production, by the pricking of a needle, of a double sensation, the second being painful; it is noted in tabes dorsalis.

REUSNER'S SIGN OF EARLY PREGNANCY—An increase in the volume of the pulsation of the uterine arteries may be perceived through the vagina in the posterior culdesac as early as the fourth week.

REVILLIOD'S SIGN—Inability of the patient to close the eye of the affected side only; it is observed in paralysis of the superior facial nerve in hemiplegia.

RICHARDSON'S SIGN—The application of a tight fillet to the arm as a test of death. If life be present the veins on the distal side of the fillet become more or less distended.

REISS' SIGN — On listening over the stomach in cases of adherent pericardium, the heart sounds are heard loud and metallic in quality.

RINMANN'S SIGN OF EARLY PREGNANCY—Slender cords radiating from the nipple; they are considered to be hypertrophic acini of the glands.

RIPAULT'S SIGN—A change in the shape of the pupil on pressure upon the eye, transitory during life, but permanent after death.

RITTER-ROLLET'S PHENOMENON — Flex-

ion of the foot following the application of a mild galvanic current, and extension following that of a strong current.

RIVIERE'S SIGN—An area of change in percussion note denoting a band of increased density across the back at the plane of the spinous processes at the fifth, sixth, and seventh dorsal vertebræ; a sign of pulmonary tuberculosis.

ROGER'S SYMPTOM—Subnormal temperature during the third stage of tuberculous meningitis, regarded by Roger as pathognomonic of the disease.

ROMBERG'S SIGN — (1) Swaying of the body and inability to stand when the eyes are closed and the feet placed together. It is seen in tabes dorsalis, hereditary cerebellar ataxia, etc. (2) Neuralgic pain in the course and distribution of the obturator nerve, pathognomonic of obturator hernia.

ROMBERG-HOWSHIP'S SIGN—Lancinating pains in the leg occurring in incarcerated obturator hernia.

ROMMELAERE'S SIGN—Diminution of the normal phosphates and chlorids of sodium in the urine is pathognomonic of cancerous cachexia.

ROSENBACH'S SIGN—(1) Loss of the abdominal reflex in inflammatory intestinal diseases. (2) Tremor of the eyelids when the patient is asked to close them, often associated with insufficient closure of the lids. It is seen in neurasthenia.

ROSENHEIM'S SIGN — A friction sound heard on auscultation over the left hypochondrium in fibrous perigastritis.

ROSENTHAL'S SIGN—The application of a strong faradic current to the sides of the vertebral column causes burning and stabbing pains in cases of spondylitis.

ROSER-BRAUN'S SIGN—Absence of pulsations of the dura in cases of cerebral abscess, tumors, etc.

ROTCH'S SIGN—Dullness on percussion in the right fifth intercostal space in pericardial effusion.

ROTH'S SYMPTOM-COMPLEX — "Meralgia paresthetica." Numbness, pain on exertion, and hyperesthesia of the part of the thigh supplied by the external cutaneous nerve.

ROTHSCHILD'S SIGN—(1) Preternatural flattening and mobility of the sternal angle, seen in phthisis. (2) Rarefaction of the outer third of the eyebrows in thyroid inadequacy.

ROUSSEL'S SIGN—Sharp pain on light percussion on the subclavicular region, between the clavicle and the fourth rib; a sign of incipient tuberculosis.

ROVIGHI'S SIGN — Hydatid fremitus; a thrill observed on combined palpation and percussion in cases of superficial hyatid cyst of the liver.

ROVSING'S SIGN—Pressure on the left side over the point corresponding to McBurney's point will elicit the typical pain at McBurney's point in appendicitis, but not in other abdominal affections.

RUMPEL-LEEDE'S SIGN—The appearance of minute subcutaneous hemorrhages below the area at which a rubber bandage is applied not too tightly for ten minutes upon the upper arm; characteristic of scarlet fever.

RUMPF'S SIGN—Fibrillary twitching of muscles in traumatic neurosea.

RUST'S SIGN—At every change of position of the body, a patient suffering from caries or carcinoma of the upper cervical vertebras, supports his head with the hand.

SAENGER'S SIGN—A light reflex of the pupil that has ceased returns after a short stay in the dark, in cerebral syphilis, but not in tabes dorsalis.

SANDER'S SIGN—Undulatory character of the cardiac impulse, most marked in the epigastric region, in adherent pericardium.

SANSOM'S SIGN—(1) Considerable extension of dullness in the second and third intercostal spaces in pericardial effusion. (2) A rhythmic murmur transmitted through the air in the mouth when the lips of the patient are applied to the chestpiece of the stethoscope. It is heard in cases of aortic aneurysm.

SARBO'S SIGN—Analglesia of the peroneal nerve, occasionally observed in tabes dorsalis.

SCHAPIRO'S SIGN — No slowing of the pulse-rate on lying down. Indicative of weakness of the heart muscle.

SCHEPELMANN'S SIGN—In dry pleurisy the pain is increased when the patient bends his body toward the well side, whereas in intercostal neuralgia it is increased by bending toward the affected side.

SCHICK'S SIGN—Stridor heard on expiration in an infant with tuberculosis of the broncheal glands.

SCHLESINGER'S SIGN—In tetany if the patient's leg is held at the knee joint and flexed strongly at the hip joint, there will follow within a short time an extensor spasm at the knee joint, with extreme supination of the foot.

SCHLUNGE'S SIGN—Lack of peristalsis below the seat of intestinal obstruction, with dilatation above it.

SCHULE'S SIGN—Vertical folds between

the eyebrows, forming the Greek letter omega (omega melancholicum), frequently seen in subjects of melancholia.

SCHULTZE-CHVOSTEK'S SIGN—See Chvostek's Sign.

SEELIGMUELLER'S SIGN — Mydriasis on the affected side in cases of neuralgia.

SEGUIN'S SIGNAL SYMPTOM—The initial convulsion of an attack of Jacksonian epilepsy, which indicates the seat of the cortical lesion.

SEITZ'S SIGN — Bronchial inspiration which begins harshly and then becomes faint; indicative of a cavity in the lung.

SEMON'S SIGN — Impaired mobility of the vocal cord in carcinoma of the larynx.

SHELLY'S SIGN—A sago-like eruption on the palate and lips in influenza.

SICAR'S SIGN—A metallic resonance on percussion with two coins on the front of the chest and auscultation at the back, observed in some cases of effusion within the pleura.

SIEUR'S SIGN—A clear, metallic sound sometimes heard in cases of pleural effusion on percussing the chest in front with two coins and auscultating behind.

SIGNORELLI'S SIGN—Extreme tenderness on pressure on the retromandibular point in meningitis.

SILEX'S SIGN—Radial furrows about the mouth, and coincidently in other parts of the face; a pathognomonic sign of congenital syphilis.

SIMON'S SYMPTOM—Immobility or retraction of the umbilicus during inspiration, sometimes seen in tuberculous meningitis.

SKEER'S SIGN—A yellowish-brown ring near the pupillary margin of the iris, observed in the early stage of some cases of tuberculous meningitis.

SKODA'S SIGN — A tympanitic sound heard on percussing the chest above a large pleural effusion or above a consolidation in pneumonia.

SMITH'S SIGN — A murmur heard in cases of enlarged bronchial glands on auscultation over the manubrium with the patient's head thrown back.

SPIEGELBERG'S SIGN — A sensation like that of passing over wet india-rubber, imparted to the finger which presses on and moves along the affected part; it is noted in cancer of the cervix uteri.

STELLWAG'S SIGN—Absence or diminution in frequency of the winking movements of the eyelids and abnormal width of the palpebral aperture; it is seen in exophthalmic goiter.

STERLES' SIGN—Increased pulsation over the cardiac region in intrathoracic tumors.

STERNBERG'S SIGN—Sensitiveness to palpation of the muscles of the shoulder-girdle in pleurisy.

STEWART-HOLME'S SIGN — The patient rests his elbow on the table and the examiner grasps his wrist. The patient then tries to flex his arms against the resistance of the examiner. When the wrist is released, flexion occurs, but is again arrested by the contraction of the triceps, in normal patients, but in hypotomia, flexion of arm continues without action of the triceps.

STILLER'S SIGN — Marked mobility or fluctuation of the tenth rib in neurasthenia and enteroptosis.

STOCKER'S SIGN—In typhoid fever, if the bed-clothes be pulled down, the patient takes no notice; but in tuberculous meningitis the patient resents the interference and immediately draws the clothes up again.

STOKES' SIGN — A violent abdominal throbbing felt on palpation to the right of the umbilicus in acute enteritis.

STRAUS' SIGN—In facial paralysis from a central cause, the hypodermic injection of pilocarpin causes no appreciable difference in the perspiration of the two sides, either as to time or quantity, whereas there is a marked retardation of the secretion on the effected side in severe peripheral paralysis.

STRUMPELL'S SIGN—(1) Dorsal flexion of the foot when the thigh is drawn up toward the body; seen in a paralyzed limb. (2) Dorsal flexion of the great toe in an extremity affected with paresis.

STRUNSKY'S SIGN—A sign for detecting lesions of the anterior arch of the foot. The examiner grasps the toes and flexes them suddenly. This procedure is painless in the normal foot, but causes pain if there is inflammation of the anterior arch.

TARNIER'S SIGN—Effacement of the angle between the upper and lower segments of the uterus; it is an indication of inevitable abortion.

TAY'S SIGN—A red spot seen on the retina of each eye in the region of the macula lutea in amaurotic family idiocy.

TELLAIS' SIGN—Pigmentation of the eyelid in exophthalmic goiter.

TESTIVIN'S SIGN—The formation of a collodion-like pellicle on the urine after removing the albumin and treating with acid and then with one-third of its volume of ether; said to occur during the incubation of infectious diseases.

THEIMICH'S LIP SIGN—A protrusion or

pouting of the lips elicited by tapping the obicularis oris muscle.

THORNTON'S SIGN—Violent pain in the flanks in nephrolithiasis.

TOMA'S SIGN—In ascites from peritoneal inflammation when the patient lies on his back percussion on the right side gives tympany; on the left side, dullness.

TOURRETTE'S SIGN—Inversion of the ratio existing normally between the earthy phosphates and the alkaline phosphates of the urine; it is found in paroxysms of hysteria.

TRAUBE'S PHENOMENON — A double sound, systolic and diastolic, heard over peripheral arteries, especially the femoral, in aortic insufficiency; occasionally also in mitral stenosis, lead-poisoning, etc.

TRESILION'S SIGN — A reddish appearance of the Stenson's duct in mumps.

TROISIER'S GANGLION OR SIGN—Enlargement of the left supraclavicular lymphglands, an indication of malignant diseases of the intraabdominal region.

TROUSSEAU'S SYMPTOM—The production of paroxysms of tetany by pressure upon the principal nerve trunks or blood-vessels of the parts affected. It is observed in tetany.

TURGENSEN'S SIGN—Crepitant rales; regarded as a sign of tuberculous pleurisy.

UHTHOFF'S SIGN — The nystagmus of multiple cerebrospinal sclerosis.

UNSCHULD'S SIGN — A tendency to cramps in the calf of the legs; it is an early sign in diabetes.

URIOLLA'S SIGN—The presence in the urine of malarial patients of minute black granules of blood-pigment.

VANZETTI'S SIGN—In sciatica the pelvis is always horizontal in spite of scoliosis; but in other lesions with scoliosis the pelvis is inclined.

VIGOUROUX'S SIGN — Diminished resistance of the skin to the galvanic current in exophthalmic goiter.

VINCENT'S SIGN—THE ARGYLL-ROBERTSON PUPIL—One which is miotic and which responds to accommodation effort, but not to light.

VIPOND'S SIGN—Generalized adenopathy seen during the incubation period of the exanthematous fevers of childhood.

VOHSEN-DAVIDSOHN'S SIGN—See Davidsohn's Sign.

VOLTOLINI-HERYNG'S SIGN — See Heryng's Sign.

VON WAHL'S SIGN—(1) Distention of the bowel (local meteorism) above the point at which there exists an obstruction; (2) a scraping or blowing sound, synchronous with the cardiac impulse, heard over an arterial trunk immediately after the partial division, through injury, of the vessel.

WARTHIN'S SIGN—Accentuation of the pulmonary sound in acute pericarditis.

WEBER'S SYMPTOM OR SYNDROME—Paralysis of the motor oculi nerve on the side of the lesion and of the facial and hypoglossal nerves and extremities on the opposite side; it corresponds anatomically to a lesion in the pedunculopontine or upper pontine region.

WEGNER'S SIGN—In fetal syphilis the dividing line between the epiphysis and diaphysis of long bones, which under normal conditions is delicate and rectilinear, appears as a broad, irregular, yellowish line.

WEILL'S SIGN—Absence of expansion in the subclavicular region of the affected side in infantile pneumonia.

WEISS'S SIGN — "Facialis phenomenon." Contraction of the facial muscles upon light percussion; it is noticed in tetany, neurasthenia, hysteria, and exophthalmic goiter.

WERNICKE'S SIGN—Hemiopic pupil reaction. Inaction of the pupil on illumination of the amaurotic half of the eye, when the hemiopia depends upon a lesion of the optic nerve between the chiasm and the external peniculate body.

WESTPHAL'S SIGN—Absence of the patellar reflex; it occurs in lesions of the spinal cord at the level of the reflex center (e.g. tabes dorsalis, paretic dementia), neuritis, certain cases of cerebellar disease, etc.

WESTPHAL-ERB'S SIGN—See Westphal's Sign.

WIDMER'S SIGN — The temperature in the right axilla is distinctly higher than the left; a sign of appendicitis.

WILKS' SYMPTOM-COMPLEX—ERB'S DISEASE—Idiopathic muscular atrophy.

WILLIAM'S SIGN — Diminished inspiratory expansion on the left side in adherent pericardium.

WINTRICH'S SIGN — A change in the pitch of the percussion note when the mouth is opened and closed. It indicates a cavity in the lung.

WOLFER'S SIGN—In hour-glass stomachs fluids pass quickly, but on subsequent lavage the water contains food and foul matter.

WOLKOWITCH'S SIGN — Marked relaxation of the abdominal muscles of the right side in chronic recurrent appendicitis.

WREDEN'S SIGN—Presence in the external auditory meatus of a gelatinous mat-

ter in children who are born dead.

ZAUFAL'S SIGN—Saddle-nose.

ZUGSMITH'S SIGN — Abnormal dullness on percussion in the second interspace for a variable distance on both sides of the sternum. Seen in gastric ulcer and carcinoma.

An Unprecedented Opportunity for Women.

EMMA WHEAT GILLMORE, M.D.
Chairman Committee of Women Physicians, General Medical Board, Council of National Defense.

The same year that gold was discovered in California, a lone pioneer received the first medical diploma which the United States had issued to a woman. Other colleges shortly followed the example of the one which had opened its doors to Elizabeth Blackwell, and today over fifty coeducational medical schools admit women upon the same terms as men.

There are more than 25,000 American physicians in military service at this writing, and the Council of National Defense is undertaking, through the Volunteer Medical Service Corps — an organization which has President Wilson's approval — the task of classifying the qualifications of ninety thousand more. Of these, about six thousand are women, less than one-third of whom have registered with the General Medical Board.

Women of the profession, unless our qualifications are standardized and on file, can you not see that we are an unknown quality and quantity as far as the Government is concerned? In spite of the overwhelming difference in number—6,000 women and over 100,000 men—and regardless of the fact that over twenty-two centuries have passed since Hippocrates wrote the immortal oath and only sixty-nine years have elapsed since women entered the medical profession, the Volunteer Medical Service Corps has invited them to membership with the same impartial cordiality as it has the men.

During the last week in August application blanks for the Volunteer Medical Service Corps were mailed in franked envelopes to all legally qualified men and women in the United States who were not already in Government service. Presumably a number of women have been overlooked because many of them are not members of medical societies, but this will speedily be corrected if a notification of the omission is sent to the Volunteer Medical Service Corps, Council of National Defense, Washington, D. C.

Meanwhile, medical women who possess a vision will see in the Volunteer Medical Service Corps an incomparable method of organization which will register their qualifications and place them in an identical coded class system with men physicians. This corps is in reality an ideal procedure for mobilizing the military forces of our country for selective medical war service. Incidentally it will place loyal and patriotic medical women by the side of those men who are willing to give themselves. Even though all of them are not elected to membership, their names will be on file with the Government as willing to serve as far as their strength and capability will permit, and no one can point a finger at them and say "slacker."

Will a page be turned over in the history of American Medical Women upon which will be written the qualifications of 6,000 of them, matching that group of English physicians known as the Scottish Women's Hospitals, which was so perfectly organized that they were able to hand over to their Government a constructively organized body of professional women for military service? Or shall we continue, as we have done in sporadic groups for the past sixty-nine years, to demand recognition of men and at the same time neglect to unanimously affiliate with them in recognized medical societies, and to withhold our influence both with pen and vote when medico-social and medico-political and medico-scientific issues are at stake which shake the very foundation upon which medicine rests?

The body politic of the civilized world holds a prominent place for the profession of medicine in the near future. Are we to have a hand in shaping it? The Volunteer Medical Service Corps is big with promise for women of the medical profession if we take advantage of it to put ourselves on record. The response which the Council of National Defense receives from women who apply for membership will tell the tale as to whether they have or have not grasped and taken advantage of the unprecedented opportunity which this world's war for democracy has opened up for them through the medium of the Volunteer Medical Service Corps.

For artillery, automatic rifles, and small arms, and for ammunition for them, we have spent over $3,700,000,000. Every Liberty Loan subscriber helps to arm our soldiers.

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What Is Pernicious Anemia?

In spite of the very definite symptom grouping, and the very characteristic blood picture that has been offered us, the problem of what progressive pernicious anemia is still remains to be solved.

From the great mass of literature one derives but a hazy conception of this disease, which seems to have a fairly definite pathology and a great variety of possible etiologic factors. There seems to be no unanimity in fixing the proper limits for the use of the term and no concensus of opinion as to the essential feature in its pathology. While some believe that it should be regarded merely as a symptom-complex which may be caused by a variety of pathological processes, others believe that it should be dignified as a separate clinical and pathological entity.

Whichever of these views be accepted, however, if the clinical picture is sufficiently constant to be distinctive, it would seem that the matter of a discoverable relation to some causative factor should play a less important part in its diagnosis than the numerous controversies indicate. No good purpose can be accomplished by giving one identity to a symptom-complex occurring in a group of cases in which the causes are definitely known, and another identity to a strikingly similar or identical symptom-complex in a group of cases in which the causes have not yet been determined. The presence of known causes does not prove that we have to do with merely a symptom-complex in the one instance, nor does the absence of known causes prove that we have to do with a clinical and pathological entity in the other.

It is very evident, however, that one of the greatest obstructions to a clear conception of the various opinions and theories advanced lies in the very indefinite scope of the term progressive pernicious anemia. While some would limit the use of the term to those cases in which the most thorough examination of the patient fails to show any primary disease, others believe there should be included all those cases which show a characteristic blood picture without regard to etiologic findings. Ewing, for instance, believes that the changes in the blood and marrow described in pernicious anemia result from a peculiar pathologic process which is essentially different from that seen in the majority of secondary anemias, and that when the blood contains megaloblasts and a considerable number of megalocytes with increased Hb, while the lymphoid marrow shows marked hyperplasia of peculiar type, the condition should be called progressive pernicious anemia without regard to its immediate exciting cause.

In a condition in which the deviation from the normal seems to be marked by an unusual process of destruction and an exaggerated process of regeneration, it seems logical at least to conclude that the destructive process should be regarded as the essential pathologic one. And yet, in this particular instance, there are some fairly good grounds for a contrary opinion.

There are sufficient evidences of a very marked and, perhaps, unusual type of hemolysis to be found in the excessive deposits of iron in the liver and other organs, in the hemoglobinuria, the pathologic urobilinuria and the clinical symptoms. There is also evidence that the hemolysis precedes in many instances the appearance of the evidences of unusual hematogenesis and

in some cases death has occurred, apparently from the excessive hemolysis, before any evidence of increased hematogenesis has been established. It has also been shown that from the prolonged effect of certain blood solvents a condition strikingly similar to, if not identical with, progressive pernicious anemia may develop.

There seems to be a considerable number and a considerable variety of influences that are capable of causing an excessive hemolysis, but not in all of them is the hemolysis associated with an excessive or unusual hematogenesis. On the other hand the most characteristic feature of pernicious anemia, or at least the elements of its distinguishing blood picture, result from an unusual or defective hematogenesis.

If we assume that excessive hemolysis is the essential pathologic feature; that the excessive hematogenesis is a regenerative or reparative process; and that the characteristic elements in the blood picture of pernicious anemia are the results of this extreme effort at repair, then these elements of the blood picture are not of so much importance in the diagnosis of the disease as in determining a stage in its progress.

While this view of the pathologic importance of an excessive hemolysis seems to be held by a large majority of contributors to the literature on the subject, there is a very impressive array of supporters of the view that progressive pernicious anemia results through *defective* hematogenesis, and that the characteristic elements of the blood picture result from a defective rather than an excessive hematogenesis. It is claimed by some of these that while excessive hemolysis may precede or occur without a defective hematogenesis, it is of a different kind from that associated with megaloblastic changes; and that only the presence of defectively formed red cells renders such a hemolysis possible. They claim that the megaloblastic degeneration of the marrow is the pathognomonic tissue lesion and excessive hemolysis a constant result.

With the acceptance of this view the diagnosis must of course be based upon the finding of characteristic blood cells resulting from this defective hematogenesis.

It would seem, however, that with either view of the essential pathology of this disease the scope of the term progressive pernicious anemia must be enlarged so as to embrace many of the anemias not now regarded as belonging to the pernicious form.

Upon the constancy of the characteristic blood picture and its definite relation to the pernicious form of anemia there is considerable skepticism among the contributors to the literature of the past few years. Ward (London, 1914) says: "In a typical advanced case the condition of the blood is very striking but the suggestion that the disease can be diagnosed by an examination of the blood alone is fallacious * * *. It is of course true that the 'pernicious anemia' type of blood is more commonly met with in Addisonian anemia than in any other disease, but it is equally true that it may be met with after hemorrhage, in cancer, in those who have been poisoned by certain drugs or their fumes, in many septic troubles, in leukemia and in a variety of other conditions."

Among those who accept the excessive hemolysis as the essential pathologic process it is sometimes suggested that the defective hematogenesis, manifested by the characteristic abnormal blood cells, is the result of certain structural changes in organs which have been permanently damaged by the excessive hemolysis, or the agent which is responsible for the hemolysis. This seems to be borne out by the fact that during the periods of improvement, which occur sometimes without any particular treatment and sometimes are apparently the result of certain remedial measures, the so-called pernicious cells do not disappear from the blood picture.

But one may also interpret the persistence of these cells during the periods of remission, in which the patient is sometimes restored to nearly a normal state of

health, as evidence that the presence of these cells in the blood bears no relation to the symptomology of the disease, and for the same reason no relation to its essential pathology.

———B———

Influenza.

It seems to be the same old influenza which the newspapers have attempted to camouflage under a new name. It is the same old fast-moving soul-disturbing life-destroying epidemic disease that the Italians named *influentia,* the French called *la grippe* and to which the Germans gave a like expressive name, *blitz katarrh.* It has been a more or less freuent visitor to the inhabited portions of the globe since before the Christian era. At least it was claimed by Guiteras that an outbreak of the disease occurred in the Athenian army in 415 B. C.

Some of us have very vivid recollections of the epidemic which reached this country in December, 1889, and spread rapidly over the greater part of the United States. During the period of that epidemic there was much speculation as to the etiologic factor, for it was not until 1892 that a bacillus was discovered in the pus-cells of the tracheal mucus by Pfeiffer, and in the blood by Canon, that could reasonably be credited with its cause.

It was generally conceded by the writers at that time that sudden changes in temperature, moisture and electric conditions of the atmosphere were important factors in the rapid spread of the disease, but there is nothing in the history of these epidemics to bear out that opinion. The records of careful meteorological observations made in Chicago during the prevalence of the epidemic in 1889-'90 showed the presence in the air of a decided excessive amount of free and albuminous ammonia, with almost entire absence of ozone. Nothing, however, was determined as to any influence this might have had on the rapid evolution of any probable active agent in the etiology of the disease.

The rapid spread of the infection, its almost simultaneous appearance in widely separated localities, and the fact that persons said to be in complete isolation were attacked, naturally suggested that the essential etiologic factor must be capable of rapid development and wide diffusion in the air.

The data to be obtained during so prevalent an epidemic are largely too unreliable for an accurate determination of the methods of transmission, but it is fairly safe to assume that transmission is by human contact or by the secretions from infected people. In those individual cases where contagion seems to have occurred without exposure the mystery usually disappears with the discovery of all the facts.

Lieut. J. J. Keegan, M. C. U. S. N.. (Jr. A. M. A., Sept. 28) reports some difficulty in finding the influenza bacillus in the secretions from the mouth and throat or in the blood in these cases. This he explains by the difficulty of isolating the influenza bacillus from mixed cultures, and also by the fact that it probably selects the posterior naso-pharynx rather than the pharynx for its most abundant growth. Smears and cultures from lung punctures and necropsies gave more definite results, for in these the influenza bacillus occurred either in pure or mixed culture in 82.6 per cent of the twenty-three cases studied, and in 31.6 per cent of these in pure cultures.

In a report by A. Hewlett, Surg. U. S. N. R. F., and W. M. Alberty, Asst. Surg. U. S. N. (Jr. A. M. A., Sept. 28) we find the following: "The Pfeiffer influenza bacillus has been isolated from a varying proportion of patients; but many observers have failed to find this organism with any regularity. It is quite possible, indeed, that this organism is not responsible either for the present epidemic or for the pandemic of 1889-1890."

Since the etiology of the epidemic in 1889 was undetermined and there is yet considerable confusion as to the cause of the present epidemic, any attempt to identify them as of the same character must depend upon the symptomatology.

In the literature of the time we find the general symptoms of the disease as it oc-

curred in 1889 as follows: There was no well defined period of incubation and generally no prodromal stage. The onset was remarkably sudden, beginning with chilly sensations often increasing to a chill. There was general depression with pains in the head, back and limbs. Pulse and respiration were variable, both increasing in frequency as the temperature rose. The temperature ranged from 100 to 104.5 F. The skin was dry, urine scanty and high-colored. There was constipation, no appetite, but some thirst. In a large majority of cases there was redness of the conjunctivæ, congestion of the mucous membranes of the nose, pharynx and bronchial tubes, with cough and oppression. During the second day the secretion of mucus was abundant and by the fourth day the nasal discharges and expectorations were mucopurulent. At this time the other symptoms were ameliorated. The duration was from one week to ten days. There were many individual variations from the general clinical picture and there were many and varied complications, the most frequent and most fatal of which was pneumonia. The mortality from uncomplicated influenza was very small, nearly all of the deaths reported being due to pneumonia, phthisis, senility, cerebral affections and other complications.

The clinical reports so far received from the districts already invaded do not differ in any essential feature from those of 1889. In Supplement No. 33 of the Public Health Reports, under date of Sept. 27, 1918, we find the following description of the onset and course of the disease:

"The symptoms in the present pandemic have been an acute onset, often very sudden, with bodily weakness and pains in the head, eyes, back, and elsewhere in the body. Vomiting may be a symptom of onset and dizziness is frequent. Chilly sensations are usual, and the temperature is from 100 to 104 degrees, the pulse remaining comparatively low. Sweating is not infrequent. The appetite is lost, and prostration is marked. Constipation is the rule. Drowsiness and photophobia are common. The conjunctivæ are reddened, and the mucous membrane of the nose, throat, and bronchi often give evidence of inflammation. The general symptoms, however, predominate over the local. Cervical and general lymphadenitis and nystagmus have been reported to be very frequent by certain observers. Charactestically, there is no leucocytosis during the height of the fever, so that a high white count during the first sixty hours is indicative of another disease or of complication. The fever usually lasts from three to five days; but relapses are not uncommon, and complications, particularly pulmonary, are to be feared. The death rate is usually given as extremely low; but in the latter periods of an outbreak an increased number of deaths, presumably due to complications, has been reported in Spain and in the United States. Besides bronchitis and pneumonia, inflammation of the middle ear and cardiac weakness may follow the disease."

From observation of cases that developed in the hospital staff, Keegan fixes the incubation period at from one to two days. He did not observe coryza or sore throat during the early period. Hewlett and Alberty, however, found irritation in the upper respiratory tract with dry cough and soreness of the throat in two-thirds of their cases.

During the epidemic of 1889, or during the latter part of the epidemic period, there were a considerable number of cases in which gastro-intestinal symptoms predominated, and another considerable number in which the nervous system seemed to be most prominently involved.

Extreme cardiac weakness is one of the conditions prominently mentioned in connection with this epidemic; and it was also, in the earlier epidemic, one of the very important symptoms, leading to a long and tedious convalescence and sometimes to a permanent impairment of health. It undoubtedly was a significant factor in the high mortality from pneumonia.

In the epidemic of 1889, quinine was regarded by a large majority of the writ-

ers as nearest to a specific. It was used as a prophylactic and a curative agent. It is unnecessary to say that it was far from a specific, but it seemed to have as much effect upon the duration of the disease as most of the remedies used. In the painful conditions antipyrine and phenacetine were commonly prescribed, but many writers ascribed the depression and cardiac weakness to the too liberal use of these drugs. A prescription recommended by Baccelli was as follows:

℞ Quin. salicyl. 3 grains
Phenacetine 3 grains
Camphor ⅛ grain M.

This was to be given six times in twenty-four hours. Stimulants were regarded as an essential part of the treatment in the cases where depression was marked, and in the pneumonic cases.

As to the treatment in the present epidemic, very little has been reported. There seems to be a general impression that acetylsalicylic acid may be of benefit, but beyond that symptomatic treatment is advised.

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The V. M. S. C.

The real loyal men of this country are not those who sit up nights to devise plans for their own aggrandizement, nor those who are losing sleep in worrying over the honor or credit some other fellow may get out of the war; but the men who are quietly and unostentatiously performing to the best of their ability the duties assigned to them. They care nothing about the pedigree, the social history, or the political ambitions of the men who give the orders, if they have the authority. All they care to know is how, when and where they can be of service.

Such at least are the men in Kansas who, without hesitation, signed the applications for membership in the Volunteer Medical Service Corps. The President's letter of approval indicated that he believed that it would be of some assistance, and that was sufficient.

We do not know what the plans of the organizers of the association are nor how they are to be carried out. Although the developments up to this time do not seem to justify the trouble and expense, we can see great possibilities in such an organization, under a wise and judicious administration of its affairs.

We have reason to believe that a large number of the physicians of Kansas signed applications, but we know of no one having been admitted to membership — yet. The only indication that any members are recognized in the state was the announcement some days ago of the selection of certain men for special duties in connection with the epidemic.

This is no time for us to grow hysterical over the possibility that the officers of this may usurp the prerogatives of the officers of some other organization. Those are matters in which the physicians of Kansas have no voice in times of peace, and certainly not matters about which we should concern ourselves in time of war. If, as seems to be implied by certain criticisms, this organization is only intended for the aggrandizement of some of the men occupying semi-authoritative positions, or if it is intended to interfere with the proper functions of any other organization or with the regularly constituted health authorities, then the keenest disappointment will be felt by those who have permitted themselves to imagine that the medical profession could be used to further such motives. On the other hand, if this organization should prove to be of material benefit to the government or to any of the auxiliary bodies, then the psysicians who have given their pledges will have the satisfaction of knowing that they have unhesitatingly showed their willingness to respond when their help is needed.

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Deaths.

Emerson K. Kellenberger, Yates Center, Kansas; Medical College of Ohio, Cincinnati, Ohio, 1871; aged 68; a Fellow of the American Medical Association and president of the Woodson County Medical Society in 1914; for twenty years local surgeon for the Missouri Pacific Railroad

Company; for two years coroner of Franklin County, and secretary of the first board of medical examiners of his judicial district; died at his home, September 11, from cerebral hemorrhage.

Dr. W. J. Mayo said: "One of the typical features of splenic anemia is the occurrence of hemorrhage from the stomach. Possibly seventy-five per cent of all the severe hemorrhages from the stomach do not have their origin, as is so frequently thought, in peptic ulcer, but arise from some unknown gastrotoxic condition."

We have spent over $120,000,000 just for staple supplies for our army, such as flour, bacon, rice, etc. Every subscriber to the Liberty Loan bonds helps feed our soldiers.

BOOKS.

Surgical Treatment—Volume 1.

A practical treatise on the therapy of surgical diseases for the use of practitioners and students of surgery. By James Peter Warbasse, M.D., formerly attending surgeon to the Methodist Episcopal Hospital, Brooklyn, New York. In three large octavo columes, and separate desk index volume. Volume 1 contains 947 pages with 699 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Per set (three volumes and the index volume), cloth, $30 per set.

We have just received the first volume of Warbasse's Surgical Treatment. In this volume the author has discussed the following subjects: General Principles of Surgical Treatment; Asepsis and Antisepsis; Surgical Materials, Their Preparation and Sterilization; Anesthesia and Anesthetics; Wounds and Operations; Inflammations; Surgical Fevers and Infections; Fistula and Sinuses; Ulcerations and Gangrene; Nutritive Disturbances; Tumors; Blood and Blood Vessels; Lymphatic System; Diseases of Bones; Fractures; Dislocations; Diseases of Joints; Operations on Bones and Joints; Muscles, Tendons, Fascia and Bursæ; Skin and its Appendages; Nerves.

The technique is well illustrated and described in detail and the author has included in the text only such material as will be useful and instructive.

Military Hygiene and Sanitation.

By Frank R. Keefer, M.D., Colonel, Medical Corps, United States Army; formerly professor of military hygiene, United States Military Academy, West Point. Second edition, reset. 12-mo of 340 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $1.75 net.

This was originally prepared as a textbook for the cadets at the U. S. Military Academy at West Point. It seems to be well adapted to the needs of medical officers of the army and particularly those in the training camps.

A very instructive chapter on physical training was supplied by Capt. H. J. Koehler, U. S. A.

While prepared particularly for those in charge of military camps, there is much in this book that will be adaptable to the needs of those in civil life.

Gynecology.

By William P. Graves, M.D., professor of gynecology at Harvard Medical School. Second edition, thoroughly revised. Octavo volume of 883 pages with 490 original illustrations, 100 of them in colors. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $7.75 net.

The second edition of this work shows a considerable revision of the text and some very important new material has been added. The author has rewritten the chapter on the Relationship of Gynecology to the Internal Secretions and has added to the discussion of ovarian organotherapy, ovarian transplantation, the radium treatment of cancer and in nonmalignant diseases. A new section has been added dealing with the relationship of gynecology to the sex impulse.

The work is excellently illustrated and in this edition many new cuts are used.

The Orthopedic Treatment of Gunshot Injuries.

By Leo Mayer, M.D., instructor in orthopedic surgery, New York Postgraduate medical School and Hospital, with an introduction by Col. E. G. Brackett, M.C.N.A., director of military orthopedic surgery. 12-mo of 250 pages, with 184 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, $2.50 net.

This, like a good many of the recent publications, is prepared with special reference to the requirements of war surgery. The orthopedic treatment of war injuries is something that should stimulate the inventive genius of our American surgeons. There is much room for improvement and a book like this, while showing us the construction and application of the various appliances now in use, gives us just an idea of how great the need for improvement is.

The author shows how a proper fixation of an injured part may be accomplished in the field and also how best to restore motion in the ultimate treatment of the case. Several extension appliances and artificial limbs are described.

Can the Young Physician Catch Up?

Dear Editor: I read in our valued Journal, September issue, "Can the Old Physician Come Back," and the writer says most physicians who have practiced medicine for from twenty to thirty years begin to slow down. They accomplish less work, they are less thorough and systematic in their examinations—depending more upon intuition or observation, perhaps. And are prone to follow along older lines of treatment." I want to remonstrate against this unthoughted foolishness. Now we all love the young physician, and all of us have hopes that some day we will be able to say he is a well rounded up man, and a physician who will be of real benefit to the community he may reside in. But when you say the old physicians accomplish less work and are less thorough in their examinations, this does not agree with my experience in my locality or with the physicians of the county in which I reside. I will admit the young man may burn up the road and use more gasoline and will not consume as much time in examining the patient; but how about the patient, if the poor fellow is really sick? Wouldn't it be better to take a little time and make a more thorough examination and know what is the matter, which the old physician will most assuredly do.

"They study less"—no, when the old physician is not busy with patients he is studying, he is reading medicine; how about the young physician when he is not busy with patients?

They say the old doctor will need a new library. Not in our county, the middle-aged and older doctors have the libraries.

Some time ago I was talking with a representative of one of the large medical book houses, and he told me the middle-aged and old doctors bought the books. He said the young doctor was a very poor book buyer.

But let us dwell together in unity, there is a place for the old physician as well as the young. And when the old professor signs the young man's diploma, is his life's work complete? No; he is just getting ready to enter the race, and when he comes home let us encourage him to run faster and faster; it will take him about ten years to catch up with the band wagon, where he can hear the sweet strains of music and see the real great things in his professional work and the great good he may be able to accomplish in the world.

No; do not ask the old doctor to come back, but encourage the young doctor to catch up. E. G. M., Kansas.

OFFICIAL ANNOUNCEMENT.

The Volunteer Medical Service Corps.—An Appeal to Executive Committees and County Representatives of the Volunteer Medical Service Corps, and State Committees of the Council of National Defense.

No official or committeemen representing the Volunteer Medical Service Corps or the General Medical Board of the Council of National Defense, is now authorized or has been authorized to favor any organized or unorganized method of coercion in inducing members of the medical profession to join the Medical Corps of the Army or Navy, or the Volunteer Medical Service Corps. Our committeemen are especially urged against favoring any movement that would threaten to impair a medical man's standing in his local, state or national society because he refused to enroll in the Army or Navy, or the Volunteer Medical Service Corps.

It must be made clear that the Volunteer Medical Service Corps is a volunteer organization which has for its object the enrollment and classification of the profession. Its members are entitled to wear an insignia which will clearly indicate that they have offered their services to the Government, when such services are needed. Patriotism cannot be created by coercion. It also must be made clear that the Volunteer Medical Service Corps has for its primary object furnishing its classification to the Army, the Navy, the Public Health Service, the Red Cross and Provost Marshal, as well as to civilian institutions and communities, as a guide in providing for their needs to the best advantage.

The object of the Corps is not to disturb any medical man in the performance of

any duty to which he has been assigned by any governmental agency either for service at the front or at home.

EDWARD P. DAVIS, President,
Volunteer Medical Service Corps.
FRANKLIN MARTIN, Chairman,
General Medical Board, Council of National Defense.

To the Army and Navy.

The following physicians of Kansas have been reported as having accepted commissions in the army and navy since September 1:

R. S. Pickler, Beloit
A. W. Lovene, Burdick
S. H. Kellam, Cherryvale
W. S. Prout, Concordia
W. H. Young, Fredonia
B. B. Mason, Grenola
A. J. Lind, Kansas City
J. W. Risdon, Leavenworth
D. R. Sterrett, Leavenw'th
B. H. Jordan, Medicine Lodge
R. A. Taylor, Meriden
C. L. Randall, Neodesha
F. A. Trump, Ottawa
H. A. Alexander, Topeka
H. W. Gootee, Topeka
W. H. Weidling, Topeka—Navy
E. M. Ireland, Coldwater
F. A. Eckdall, Emporia
H. P. Knowles, Sterling
G. H. Allen, Topeka
A. H. Nossaman, Whitewater
M. F. Russell, Great Bend
G. C. Mahaffey, Ottawa
H. A. Vincent, Perth
W. V. Hartman, Pittsburg
E. G. Padfield, Salina
G. C. Funk, Smith Center
W. H. Robinson, Eudora
E. E. Haynes, Madison
E. F. Clark, Mayfield
R. M. Tinney, Norton
F. A. Carmichael, Osawatomie
O. R. Brittain, Salina
J. H. O'Connell, Topeka

Orders to officers of the Medical Corps:

To Camp Dodge, Iowa—Lieut. H. A. Alexander, Topeka.

To Camp McArthur, Texas—Capt. O. J. Corbett, Emporia; Capt. O. M. Owensby, Pittsburg; Lieut. D. L. Heidrick, Welda.

To Camp Pike, Ark.—Capt. J. A. McLaughlin, Greensburg.

To Fort Oglethorpe, Ga.—Capt. E. D. Ebright, Wichita; Lieut. C. O. Davison, Garden City; Lieut. G. K. Haughey, Wakeeney.

To Fort Riley—Capt. F. J. Walker, Wichita; Capt. P. W. Robinson, Osawatomie; Lieut. H. M. Makins, Abilene; Lieut. J. W. West, Narka; Lieut. G. H. Allen, Topeka; Lieut. W. R. Brady, Parsons; Capt. D. I. Maggard, Wichita.

To Middletown, Pa.—Lieut J. B. Edwards, Garden City.

To Jackson Barracks, La.—Lieut. J. O. Williams, Emporia.

To Report to Commanding General, Central Dept.—Capt. W. B. Coe, Waterville.

To Cambridge, Mass.—Lieut. L. G. Eastman, Auburndale.

To Camp Bowie, Texas—Lieut. R. S. Pickler, Beloit.

To Fort Sam Houston—Lieut. H. S. Kellam, Cherryvale.

To Camp Custer—Capt. L. C. Lewis, Kansas City.

To Camp Gordon—Lieut. E. D. Rodda, Armour.

To Rochester, Minn., Mayo Clinic—Capt. C. J. Magee, Leavenworth

To Walter Reed Hospital, D. C.—Capt. J. W. Faust, Kansas City.

To Beauregard, La.—Lieut. L. D. Mabie, Kansas City; Lieut. A. L. Knisely, Liberal; Capt. F. H. Slayton, Wichita.

To Camp Grant, Ill.—Capt. F. A. Carmichael, Osawatomie.

To Camp Logan, Texas—Capt. G. R. Gage, Hutchinson.

To Camp Wheeler, Ga.—Lieut. W. B. Burr, Longton; Lieut. J. H. Hansen, Elkhart.

To Walter Reed Hospital, D. C.—Lieut. W. L. Butler, Stafford.

Special War Program Arranged for the Meeting of the Medical Association of the Southwest, to be Held in Dallas, Texas, October 15, 16 and 17, 1918.

Medical matters pertaining to the war will feature this program, which promises to be the best of its kind yet offered in the South. The membership of this association is composed of physicians from the five states of Missouri, Kansas, Oklahoma, Arkansas and Texas and a large attendance is expected.

One evening's meeting will be given over to entertainment by the Dallas profession. On another evening will be shown the celebrated Government war film entitled "Fit to Fight." This will prove to be especially interesting, since a lecturer sent from Washington will speak upon the subject as the pictures are thrown upon the screen. A third evening will be occupied by Dr. Charles A. R. Campbell of San Antonio, Texas, who will deliver a lantern slide lecture, and show how the bat can be cultivated in large numbers, thereby destroying mosquitoes, and through their destruction malarial fever can be absolutely stamped out.

Every department in Washington in any manner interested in medical matters will be represented, as they have all agreed to furnish official contributions to the Dallas meeting of the association. Surgeon General Braisted of the Navy has promised to send a representative from his department, who will represent and speak for the navy medically, upon the occasion. Surgeon General Blue of the Public Health Service has promised a speaker to handle some topic dealing with the venereal disease problem as it concerns the soldier. Lieutenant Colonel Harry Mock, president of the National Association of Industrial Physicians and Surgeons, will treat some subject in relation to the work of reconstruction, as planned to be operated by the Government in the interest of its returned fighting men. The American Red Cross will be represented by Judge Quentin D. Corley, who will outline the work to be undertaken by this splendid organization in behalf of returned soldiers and sailors following the war, and illustrate same with slides. The Pure Food Department at Washington will furnish a prominent speaker, whose name will be announced later. Dr. Franklin H. Martin of the Council of National Medical Defense agreed to designate a speaker to represent his department. On account of

the absence of Surgeon General Gorgas in France, someone connected with his department is promised us, who will be present for the convention, with a timely contribution. A man of national fame will speak upon the entry of Spanish influenza to the United States and how to fight and combat it.

President Vinson of the University of Texas, or Dr. T. W. Riker of the School of History will address the convention upon the subject of "What the U. S. Government is Doing in an Educational Way for the Young Men of the Country Under the Draft Age."

A number of other prominent speakers of national reputation will be announced in a complete program of the meeting, to be made public later.

A PARTIAL PROGRAM OF THE SECTIONS ON SURGERY AND MEDICINE.

Dr. L. F. Purifoy, Eldorado, Ark., "An Unusual Case of Abdominal Pregnancy."

Dr. C. S. Holt, Fort Smith, Ark. (subject not given).

Dr. A. C. Scott, Temple, Texas, "Toxic Goiter."

Dr. M. E. Stout, Capt. M.R.C., Ft. Sam Houston, Texas, "Hernia."

Dr. Charles H. Harris, Ft. Worth, Texas, "What is the Present Day Status of the Appendix?"

Dr. John A. Lightfoot, Texarkana, Ark., "Herniotomy."

Dr. J. E. Gilcreest, Gainesville, Texas (subject to be announced).

Dr. A. D. Updegraff, Wichita, Kan., "A Plea for the Closure of Cleft Palate Before Three Months of Age."

Dr. Leo A. Sutter, Wichita, Kan., "Intestinal Obstruction Viewed from Different Angles."

Dr. A. A. West, Guthrie, Okla., "Surgical Indications in Gall Bladder Affections."

Dr. D. C. Homan, Oglesby, Texas, "Puerperal Fever."

The Dallas medical fraternity have taken active steps to arrange special clinics which will be of interest to the members of the Association, and suitable entertainment of the guests will be provided, in keeping with the occasion. A complete program will be mailed soon to the membership. Plans are being rapidly carried out to make the convention a thing to be remembered in medical history and association affairs, as a special war meeting. A large attendance is expected. In every case where possible physician members of the association should begin to lay their plans to be present, if possible, for the three days' session.

Exhibitors are invited to be present, and ample arrangements have been prepared for their displays. Any one desiring information concerning the meeting, either as regards space or other matters, is invited to address Dr. M. M. Smith, Acting Secretary and Chairman of the Arrangements Committee, at Box 207, Dallas, Texas.

Officers of the Medical Association of the Southwest: President, Dr. E. H. Martin, Hot Springs, Ark. Vice Presidents—Dr. C. Lester Hall, Kansas City, Mo.; Dr. J. N. Bonham, Hobart, Okla.; Dr. E. F. Day, Arkansas City, Kan.; Dr. M. M. Smith, Dallas, Texas. Secretary-Treasurer—Dr. F. H. Clark, El Reno, Okla. (in the service).

Volunteer Medical Service Corps of the United States.

Authorized by the Council of National Defense. Approved by the President of the United States.

INFORMATION.

1. What is the Volunteer Medical Service Corps?

The Volunteer Medical Service Corps is an organization which provides means for obtaining quickly men and women for any military or civil medical service required in the war emergency. It furnishes recommendations and necessary credentials to assure the best medical service, both military and civil.

2. How should application for membership be made?

Upon request to the Volunteer Medical Service Corps, Council of National Defense, Washington, D. C., application blanks and circulars of information will be sent. When received, the application form should be filled out completely, in accordance with instructions contained in the circular of information. The application should then be mailed to the Volunteer Medical Service Corps, Council of National Defense, Washington, D. C.

3. What is to be gained by the creation of this organization?

Placing on record all medical men and women in the United States; aiding Army, Navy, Public Health Service, Provost Marshal General's office and the American Red Cross in supplying war medical needs; providing the best civilian medical service possible; giving recognition to all who record themselves either in Army, Navy, Public Health Service, Provost Marshal

General's office, Red Cross activities or civilian service.

4. What is meant by classification?

It is the record of information furnished by the individual physician so that when the need arises, he may be requested to perform service that will be mutually advantageous to the individual and the service to which he may be assigned.

5. Who are eligible?

Every legally qualified physician holding the degree of Doctor of Medicine from a legally chartered medical school without reference to age or physical disability is eligible for membership in the Volunteer Medical Service Corps provided he or she is not already commissioned in the Government service.

6. How is eligibility to the Corps determined?

Upon information obtained from application blanks, three personal references and the executive committee of the state in which the applicant resides. Based upon the information thus secured, the Central Governing Board will finally pass upon applications.

7. Does membership in the Corps carry with it rank and pay?

This Corps is not authorized to bestow rank. Arrangements for compensation shall be made between a member requested to perform a specific duty and the agency requesting service. The matter of compensation and place of service whether with or without rank must be determined at the time said request is made. When a member of the Corps accepts service in the Medical Reserve Corps of the Army, the Naval Reserve Force, the United States Public Health Service, the American Red Cross or any governmental department, he or she will be accorded the rank and pay incident to the service in the department in which he or she has enrolled.

8. Will any member of this Corps be ordered to active duty?

No member will be ordered to render any service. Requests to perform specific duties according to qualifications and availability under the classification of the Volunteer Medical Service Corps may be made from time to time as emergencies arise.

9. What will be the probable character of service members will be requested to render?

(*a*) Medical Reserve Corps.
(*b*) Naval Reserve Force.
(*c*) United States Public Health Service.
(*d*) American Red Cross.
(*e*) Local and medical advisory boards.
(*f*) State and local health departments.
(*g*) Medical schools and hospitals.
(*h*) Industrial plants.
(*i*) Civil communities: Caring for civil communities stripped of medical attention; caring for practices of physicians in military service; reclamation of registrants rejected for physical unfitness; services to needy families and dependents of enlisted men.
(*j*) Miscellaneous service.

10. If members of the Corps are recommended for active military or naval service, in what order will they be recommended?

(*a*) Physicians under 55 years of age without dependents and without physical disabilities which are disqualifying will first be recommended. Following this group, physicians under 55 years of age without obvious physical disabilities which are disqualifying and with not more than one dependent in addition to self (Class I of the Volunteer Medical Service Corps) will be among the first to be recommended for actual war service. Any physician under 55 years of age who is without an obvious physical disability which is disqualifying and whose dependents have an income sufficient for the support of dependents other than that derived from the practice of his profession, may be recommended to enroll in the Medical Reserve Corps of the Army, the Naval Reserve Force or the United States Public Health Service when in the opinion of the respective Surgeons General his services are needed.

(*b*) Physicians under 55 years of age without obvious physical disabilities which are disqualifying and with not more than three dependents in addition to self (Class II of the Volunteer Medical Service Corps) will be the next group to be recommended to apply for active military or naval service.

(*c*) The next group recommended to enroll for active duty with the Army, Navy or Public Health Service (Class III) will be physicians under 50 years of age who are without obvious physical disabilities which are disqualifying and with more than three dependents in addition to self.

11. What are the exceptions in these groups?

The exceptions in the above groups of physicians are as follows:

(*a*) Those essential to communities.

(*b*) Those essential to medical schools and hospitals.

(*c*) Those essential to health departments.

(*d*) Those essential to industries.

(*e*) Those essential to local and medical advisory boards.

12. How will exceptions to these groups be determined?

(*a*) Essential to communities: Essential community need will be determined by the Central Governing Board on recommendation of representatives of the Central Governing Board appointed by the Board to make a survey of local conditions.

(*b*) Essential to institutions: Essential institutional need will be established after conference between representatives of the Central Governing Board of the Volunteer Medical Service Corps and representatives appointed by the governing bodies of the institutions concerned.

(*c*) Essential to health departments: Essential health department needs will be determined after conference between representatives of the Central Governing Board, Volunteer Medical Service Corps and representatives of health departments.

(*d*) Essential to industries: Essential industrial need will be determined after conference between representatives of the Central Governing Board, Volunteer Medical Service Corps and accredited representatives of industries involved.

(*e*) Essential to local and medical advisory boards: Essential local and medical advisory board needs will be determined after conference between representatives of the Central Governing Board, Volunteer Medical Service Corps and representatives of the Provost Marshal General's office.

13. When will phsicians who are not classified for actual military or naval service be requested to perform service?

When the emergency arises the following may be requested to perform duties in accordance with their qualifications and expressed merits as indicated by the information contained on their application blanks:

(*a*) Physicians over 55 years of age.

(*b*) Physicians with obvious physical disabilities which are disqualifying.

(*c*) Those rejected for all Government service because of physical disability.

14. What are some of the duties that this last group of physicians ineligible for active military service may be requested to perform?

(*a*) Deducting those members of the medical profession who will eventually be in active military, naval or public health service, fully 75 per cent of the remainder will be encouraged to continue at their home duties.

(*b*) Some of these may be called upon to supplement their private practices by performing part time service to meet community needs hitherto performed by men called to active duty.

(*c*) Twenty-five per cent of those not actually engaged in war service (possibly 20,000 in number) who are now engaged in home duties but who have agreed to do work of any kind, anywhere, upon request of the Central Governing Board, will as the emergency arises be recommended for duty in the following places: 1. Local and medical advisory boards. 2. Medical schools and hospitals. 3. Industrial plants. 4. Health departments. 5. Communities lacking medical service.

15. How does enrollment in this Corps differ from actual conscription?

The Volunteer Medical Service Corps is exactly what its name indicates. It is a gentleman's agreement on the part of the civilian doctors of the United States who have not yet been commissioned in the Army or Navy or enrolled in the Public Health Service, or in the service of the Provost Marshal General, and a representative board consisting of government officials associated with lay members of the profession in which the civilian physicians agree to offer their services to the Government if requested to do so by the Central Governing Board.

16. In what way can this Corps aid the Government?

By recording all physicians who are not yet in service and classifying them so as to utilize the talents and facilities of individuals to the best advantage and inflict as little hardship on the individual as possible, in accordance with the letter from the President of the United States authorizing the Corps "to supply the needs of the Army, Navy and Public Health Service * * * aiding in the important work of the Provost Marshal General's office and Red Cross * * * and the problems of the health of the civilian communities of the United States." It provides a method by which every physician not in uniform will be entitled to wear an insignia which indicates his willingness to serve his Government. It furnishes a method by which the medical needs of the nation may be provided for through a representative board of physicians who know the needs

of the Army, Navy, Public Health Service, Red Cross and civil communities.

17. To what extent must provision be made for essential civilian and industrial medical needs?

A large percentage of the physicians of the country will be required to care for their respective home communities and to meet civilian health needs. This percentage of necessity will be expected to maintain their home status and continue their professional work.

18. Will enrollment in the Volunteer Medical Service Corps excuse a physician in the draft age from registration under the Selective Service Law or from being classified therein?

Positively not.

19. Why then enroll in the Volunteer Medical Service Corps if it does not supplant the draft?

(*a*) Under the Selective Service Law individuals in the draft age are registered and inducted into the service as privates. The Volunteer Medical Service Corps enrolls and classifies individuals as prospective commissioned officers and will when requested assist in establishing the individual's status when he requests transfer from the enlisted forces to the commissioned branches of the service.

(*b*) Enrollment in the Volunteer Medical Service Corps definitely registers the physician as a patriot and provides definite governmental recognition of his willingness to serve.

20. Why should every physician in the United States enroll in the Volunteer Medical Service Corps?

(*a*) The unsurpassed record of volunteer enrollment for actual service on the part of the medical profession must be maintained.

(*b*) The Army and Navy must not be hampered for a moment for lack of doctors to care for the sick and wounded boys fighting our battles at the front.

(*c*) The public health must be conserved.

(*d*) The medical needs of the Provost Marshal General must be adequately met.

(*e*) The great industries furnishing materials of war employing thousands of patriotic workers, must have medical service.

(*f*) The home folks, the old and the young wearily waiting over here, must have doctors.

(*g*) Recording, classifying, and careful distribution and full utilization of our entire profession of medicine will enable us to instantly supply all demands, and our utmost resources will then be available to aid in establishing a permanent peace that will forever make this world a safe place in which women and children may live.

———R———

National Birth Control League.—A Reply

Editor Journal of the Kansas Medical Society.

Dear Sir: Your interesting editorial about our questionnaire on birth control has been called to my attention. I trust you will have space in your magazine for some comment on certain points.

We are glad to note the good will expressed in your statement that you "do not question the altruism of those engaged in this movement, nor doubt their philanthropic motives." Our motives, however, are not exactly in the philanthropic class. Philanthropy is usually only palliative, while our aim is more a fundamental social cure for human suffering, by making legal the knowledge by which people can help themselves so as to avoid much need for philanthropy.

Next you wonder at our "apparent oversight of the moral status of the legislation now in force, and of the moral and economic elements which led to its adoption." I assure you we have not overlooked this question. Indeed we have most carefully scrutinized it and the more we investigate, the more evident it becomes that the present laws tend to produce immoral instead of moral results. The laws prohibit contraceptive knowledge along with abortion and things obscene, with no distinction between them. This alone has a tendency to poison people's minds with the highly immoral assumption that the subject itself is dirty. Your inference is that morals can result from ignorance. Since when has that been true? Even assuming that contraception might be wrong, the individual who does not know how to sin is surely not so strong a character as one who, knowing, refrains. But a better and more pragmatic answer to your inference that our present laws induce morality is that in the countries having easy and legal access to contraceptive information there is a state of public morals far better than ours. The proof of the pudding is the eating.

New Zealand for instance, which has no ban on birth control information, has about the highest ratio of increase of population in the world, the lowest death rate and infant death rate on record, the most wonderful chain of maternity and baby hos-

pitals, and general social welfare laws which are acknowledged to be in the very van of progress. Does this sound like moral degeneracy? Physical and moral well being are so closely interrelated that a conclusion that New Zealand is a country in which morality is waning is impossible.

You state that you "have no means at hand for determining the accuracy" of our statement that birth control information uniformly results in a healthier, happier nation and a population which is increasing without waste. The evidence is easily secured, and as a start in acquiring it, we are sending you, with the compliments of the League, a copy of "The Small Family System," by Dr. Charles V. Drysdale of London, the well known student of this subject. In it you will find the birth and death statistics of many countries and most convincing data proving our case. We suggest that a comprehensive digest of this book would be admirable in your magazine. Again instancing New Zealand, it has a baby death rate of only fifty per thousand, while the United States has sixty big cities with a rate of over one hundred per thousand.

Next you take up our statement that the best modern scientific research has proved that wisely chosen contraceptive methods are not injurious to health. You say that reports of such research have not been widely published. True, and they will not be till the subject is taught in the medical schools and it is legal to publish the data. You further state that you doubt if medical men in general practice would "agree that the contraceptive methods in most common use are not injurious," and that "most every one has had cases in which the injury from such methods was very pronounced and unmistakable." There has been much more research abroad than here, and specific information about it may be had from men like Dr. Drysdale and Dr. J. Rutgers, head of the Neo-Malthusian League of Holland. But there is an imposing array of medical endorsement in our own country. The opinions of physicians like the following surely count: Dr. Abraham Jacobi, ex-president of the American Medical Association; Dr. L. Emmet Holt, the baby specialist; Dr. H. H. Goddard, the expert on the feeble-minded; Dr. John O. Polak, the gynecologist; Dr. Bass of Tulane University, La.; Dr. Rachel Yarros of Chicago, and many more whose names can easily be given if you wish.

We agree with you that much of the current contraceptive information illegally circulated is poor and even harmful. Like you, we have much evidence of the damage it does. That is one of the most urgent reasons for changing the laws so that the best possible scientific knowledge may be made available. We want to be free to publish a pamphlet of such information, prepared by a special committee of nationally known physicians, giving the very finest, safest information which the world affords.

You admit that contraception is now practiced by hundreds of thousands of the well to do, but you doubt if the poor are left in ignorance of the knowledge which the rich apparently get. You assert that the poor "are quite familiar with the methods used by the well to do, but are either more considerate of their health and happiness or more indifferent to the inconveniences of frequently recurring pregnancy." This we are certain is not the case. Most of the requests which come to us for information are from the poor.

You note that our arguments in the questionnaire omitted the effects on "moral and social life." As this questionnaire was sent only to health authorities and with reference primarily to individual and public health, the questions were limited to that. But if you were to read all our publications, you would see that the moral and social side has full attention. And we claim that the world's evidence is that birth control raises, not lowers moral and social standards. (I am sending you specimens of our publications.)

Your last paragraph on "virtue" seems to imply that sexual abstinence and "virtue" are synonymous. If that be true, the repeal of the laws forbidding contraceptive knowledge cannot alarm the already "virtuous." They will proceed as before, according to their principles, to live abstinent lives, except at the relatively few times when procreation is intended. So why should the program be opposed, on behalf of that kind of "virtue"? You allude to the unmarried, who "stand in greater awe of a possible inopportune pregnancy and consequent exposure and social ostracism, than of all the laws of God or man," and who therefore are "virtuous" through fear of results. You infer that it is wholesome to keep such people in fear of results and that such "virtue" should be protected by the law. Our claim is that it is high time to face the question of sex morality without fear. If our

young people can only be held to right conduct by fear, whose fault is it that their standards are so low? We elders who have brought them up have a grave responsibility and we should be heartily ashamed of ourselves if we shirk it, and depend upon our vulgar behind-the-times laws to be a substitute for the high idealism which we should teach our youth. Clean, fine, intelligent sex living is the only road to real morality.

The physicians can do more than almost any other class to raise the standard, if they will. We need their help!

Sincerely yours,
MARY WARE DENNETT,
Executive Secretary.

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Red Cross Fighting Tuberculosis in Italy.

Announcement was made today by the War Council of the American Red Cross of the personnel of the medical unit which will sail for Italy within a few weeks to conduct a health campaign in that country with the stamping out of tuberculosis as its particular objective. The movement has the fullest support of the Italian government, which intends to build permanently on the foundation laid by an educational campaign as complete and thorough as the Red Cross can make it. The sum of $1,100,000 has been appropriated to carry on the work for the last six months of the present year.

The Italian Tuberculosis Unit of the American Red Cross, as the organization will be known, will be under the supervision of Colonel Robert Perkins, Red Cross Commissioner for Italy. It was on the suggestion of Mr. Perkins that the work was undertaken. Soon after his arrival in Italy he became convinced that the Red Cross should broaden the scope of its activities in that country beyond the lines confined to war work and help the Italian government in the fight against the spread of tuberculosis. He communicated this conviction to the War Council with the result that in a little more than six weeks the medical unit has been equipped and is ready to embark on its humane mission.

Included in the personnel of the unit which numbers sixty persons, are many of the country's best known tubercular specialists, as well as physicians who have been very successful in the lines of work which they will be called upon to perform. The director of the unit is Dr. William Charles White of Pittsburgh, recognized as one of the leaders in the fight against tuberculosis in the Middle West. For ten months Dr. White has been director of the Red Cross tuberculosis unit in France. Dr. Robert H. Bishop, Jr., Commissioner of Health of Cleveland, is assistant director of the expedition. Other heads of departments are:

Dr. John H. Lowman, professor of clinical medicine at Western Reserve University, Cleveland, chief of the medical division; Dr. Louis L. Dublin of New York, statistician of the Metropolitan Life Insurance Company, chief of the division of medical statistics; Dr. Richard A. Bolt of Cleveland, connected with the health department of that city, chief of child welfare division; Dr. E. A. Paterson of Cleveland, chief of division of medical inspection of public schools; Dr. Robert G. Paterson of Columbus, Ohio, head of the tuberculosis branch of the state health department, chief of the division of education and organization; Miss Mary S. Gardner, head of the bureau of public health nursing of the American Red Cross, chief of division of public health nursing.

The executive manager of the organization is Lewis D. Bement of Framingham, Mass., and the executive secretary is Miss Bertha M. Laws of Philadelphia. Thirty-five members of the unit will sail for Italy shortly and the others will follow within a month. There will be eighteen nurses in the organization, the headquarters of which will be in Rome.

Ten traveling automobile dispensaries, three completely equipped for dental work and the others for general medical work, and fourteen motion picture machines will be taken along. It has been planned to have the publicity department attached to the unit start out several weeks in advance and awaken public interest in the movement. The motion pictures will follow with a display of health propaganda prepared in story form and then will come the members of the unit to organize the health work in each town.

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Help Needed.

The local secretary of the U. S. Civil Service Board at Kansas City has sent this office a statement of the urgent needs of the Government in the way of help in carrying on the work of the war. The greatest need at present seems to be for certain mechanics, qualified to do shipbuilding, and for stenographers, typewriters and bookkeepers, and special clerks in the departments at Washington.

The mechanics most needed just now, which can be supplied by this section of

the country, are machinists, blacksmiths and boilermakers. The ship carpenters, coppersmiths and sailmakers, and those of several other allied trades, are furnished mostly from the sections nearer the coast, but of course any who apply here will be accepted. The Kansas City Civil Service office is authorized to approve applications, hire the men and pay their way to the place of employment. This railroad fare is not held out of their wages. The pay is from 72 to 78 cents per hour.

Among the positions of a clerical nature, those requiring a knowledge of stenography and typewriting are calling for the most recruits. Two examinations for stenographers and typewriters are held every week—one on Tuesday at 9 a.m. and one on Saturday at 2 p.m. Applicants from all parts of the country may take these examinations at Kansas City, Missouri. Applications need only be submitted to the examiner on the day of examination, and do not have to be mailed into Washington, as was formerly the case. Examination papers are graded quickly and all who pass are offered immediate appointments. The entrance salary is $1,200, and promotions are rapid.

A great many technical positions are open and may be secured by simply filing an application—no examination being necessary. All such positions, however, are highly technical, and can only be secured by those especially educated and qualified for the work.

Full information may be secured by writing to the Secretary of the Civil Service Board, room 314 Post Office Building, Kansas City, Missouri.

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A Broadly Useful Hypnotic and Sedative.

As a hypnotic, Chloretone is indicated in many conditions, such as acute mania, puerperal mania, periodical mania, senile dementia, agitated melancholia, motor excitement of general paresis; insomnia of pain, as in tabes dorsalis, cancer, and trigeminal neuralgia; insomnia of mental strain or worry; insomnia of old age, nervous diseases, etc. It is often effective in these conditions when other drugs have failed.

As a sedative Chloretone is useful in alcoholism, cholera and colic; also in epilepsy, chorea, pertussis, tetanus and other spasmodic affections. It allays the nausea of pregnancy, gastric ulcer and seasickness; the nausea and vomiting of anesthesia, etc.

Chloretone acts upon the central nervous system, but therapeutic doses are said to have little or no effect upon the heart and respiratory center. The hypnotic dose for an adult is from ten to fifteen grains. Good results have been had with doses as small as seven and one-half grains. Sleep usually follows in half an hour to one hour. One large dose the second night rather than two or more smaller doses would seem to be a logical procedure. The administration of Chloretone is not attended with digestive disturbances.

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An Appeal to the Doctors and Dentists of the Country.

1. In view of the limited supply of platinum in the country and of the urgent demand for war purposes, it is requested that every doctor and dentist in the country go carefully over his instruments and pick out *every scrap of platinum* that is not absolutely essential to his work. These scraps, however small and in whatever condition, should reach Governmental sources without delay, through one of two channels:

(*a*) They can be given to proper accredited representatives of the Red Cross who will shortly make a canvass for that purpose.

(*b*) They may be sold to the Government through any bank under the supervision of the Federal Reserve Board. Such banks will receive and pay current prices for platinum.

By giving this immediate attention you will definitely aid in the war program.

2. It is recognized that certain dental and surgical instruments requiring platinum are necessary, and from time to time platinum is released for that purpose. It is hoped, however, that every physician and every dentist will use substitutes for platinum for such purposes wherever possible.

3. *You are warned* against giving scrap platinum to anyone who calls at your office without full assurance that that individual is authorized to represent the Red Cross in the matter.

F. F. SIMPSON, M.C.,N.A.,
Chief of Section of Medical Industry.

℞

Health Instructions Through Draft Boards.

Provost Marshal General Crowder recently called attention to a circular of instructions prepared by the United States Public Health Service for registrants declined in the draft because of physical dis-

of an everted vein might be successful, and he points out its theoretical advantages, such as the endothelial coat outside offering better chances of nutrition and the general probable lines of growth that might form a satisfactory duct. These theoretical advantages were not borne out by his experimental work on sixteen dogs, and the practical conclusion from these experiments seems to be that while such reconstruction is possible the outcome is unsatisfactory. The contraction of the reconstructed duct from the continued irritation of the bile tended to an ultimate occlusion by prolonged infiltration with inflammatory products. Horsley's conclusion is that the repair of any structure over which irritating discharges flow should be by means of tissues that are either wholly or partly immune to these discharges. It seems to him that the most satisfactory reconstruction occurs when the stump of the common or hepatic duct is sutured to the mobilized mucosa and submucosa of the duodenum. In this way epithelial and subepithelial layers of tissue accustomed to the biliary discharge are employed, and if accurately approximated, the corresponding tissues unite without necessarily causing contraction any more than would suturing a wound in an intestine. Such a technic has been employed by Dr. W. J. Mayo, and similar work has also been reported recently by Dr. Le Grand Guerry.

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Bacteriology of Measles.

Ludvig Hektoen, Chicago (Journal A. M. A., Oct. 12, 1918) gives a critical review of the literature of the micro-organisms of measles. The records of finding protozoa are few and largely unconfirmed. Under the head of miscellaneous come observations so fragmentary and inconclusive or made with such comparatively crude methods that they now seem of little or no value. Still this type in the literature is reviewed, apparently quite thoroughly. The principal bacilli that have been described can be roughly grouped under the heads of diphtheroid or influenza-like bicilli. The literature of this subject is pretty extensively gone over by Hektoen, as is also that of coccal infections, which play an important part in the complications and after effects. Hektoen says that the chief bacteria concerned with measles as at present known are: (1) The coccus found by Tunnicliff in the blood early in the attack and also in the throat and nose; (2) influenza bacilli, and (3) hemolytic streptococci. As opsinins and probably other bodies specific for the Tunnicliff diplococcus reach the blood in the course of the measles attack, this coccus must be of some significance, but the exact significance we have still to learn. While hemolytic streptococci seem to predominate overwhelmingly in the bronchopneumonia, their active part in the measles should be studied further, since they may spread rapidly among measles patients and largely, it would seem, by throat and droplet infection. The best way at hand to avoid serious complication of streptococcic pneumonia is early isolation of the patients to protect others against infections, including fellow patients, that may harbor streptococci. Such isolation protects against other infections also. The possible danger of streptococcus infection by food is not to be overlooked. Finally, it is evident that the immunology of the streptococci concerned, their unity or plurality, their changes in virulence, and other problems require still more investigation.

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Blood Cultures in Pneumonia.

J. E. McClelland (Cleveland), Camp Beauregard, Alexandria, La. (Journal A. M. A., Oct. 19, 1918), emphasizes the importance of blood cultures in pneumonia as shown by his experience in Camp Beauregard. He says: 1. Blood cultures in pneumonia are valuable from the standpoint of prognosis and as a guide in the serum therapy of the Type I cases. 2. Septicemia is more common with the more virulent strains of pneumococcus and with streptococcus hemolyticus. 3. Type I pneumococcus septicemia responds very promptly to immune serum treatment. 4. A moderately severe Type IV pneumococcus septicemia may be quickly recovered from. 5. The mortality in hemolytic streptococcus septicemia is very high, but one case is reported in which the patient had a slight transient septicemia and recovered."

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Sure Cure.

Doctor—You are suffering from nervous prostration. Buy a ticket for California.

Patient—Doctor, I can not leave my business now.

Doctor—You don't have to. Give the ticket to your wife.—St. Louis Globe.

℞

Italian Medical Service.

R. B. Cofield, Cincinnati (Journal A. M. A., Oct. 19, 1918), says that the infection of the knee joint is one of the most serious that the surgeon has to meet, and he describes his method of treating this based on the results achieved in the present war. The favorable results seem to depend on the following general principles: 1. The operation must be done early before there has been time for disintegration of the joint structures. 2. There must be thorough lavage of the involved areas followed by primary closure of the joint capsule. 3. Foreign bodies must not be allowed to remain within the joint cavity. 4. If drainage is used it should be carried to the joint capsule but not into the joint cavity. 5. Immobilization of the joint must be secured by adequate mechanical fixation. The cytologic investigation of the joint fluid is a distinct aid to the diagnosis, and at times to the prognosis. Cofield describes his method, which is based on the above mentioned principles. He prefers to use an active disinfectant that is penetrating as well as cleansing. Mercuric chlorid, 1:15,000, in salt solution at a temperature of about 115 F. and followed by physiologic sodium chlorid solution has proved very satisfactory. It is very important that flexion and extension of the joint should be passively carried on while the cavity is being flushed. After the operation the limb is placed in a position of physiologic rest, allowing active motion once or twice a day guided by the sense of pain.

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Mailing Yourself Money.

Every time you stick a Thrift or War Savings Stamp on your card you are mailing money to yourself to be received later with interest. Cashing in these stamps is going to be better than "getting money from home," for with the money comes the reminder that you contributed to the great victory which then will have been completely won.

———℞———

We place the quality of our advertising pages above advertising revenue. But it pays our readers because they know our columns are trustworthy.

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Advertising introduces and guarantees the merits of goods. Advertised goods must be good goods.

STATEMENT OF THE OWNERSHIP, MANAGEMENT, CIRCULATION, ETC.

Required by the Act of Congress of August 24, 1912, of the Journal of the Kansas Medical Society Published Monthly at Topeka, Kansas, for October 1, 1918.

State of Kansas, County of Shawnee, ss.

Before me, a notary public in and for the state and county aforesaid, personally appeared W. E. McVey, who, having been duly sworn according to law, deposes and says that he is the editor of the Journal of the Kansas Medical Society and that the following is, to the best of his knowledge and belief, a true statement of the ownership, management (and if a daily paper, the circulation), etc., of the aforesaid publication for the date shown in the above caption, required by the Act of August 24, 1912, embodied in Section 443, Postal Laws and Regulations, printed on the reverse of this form, to wit:

1. That the names and addresses of the publisher, editor, managing editor, and business managers are:

Name of	Post Office Address
Publisher—W. E. McVey, under direction of the Council of the Kansas Medical Society	Topeka, Kansas
Editor—W. E. McVey	Topeka, Kansas
Managing Editor—None.	
Business Manager—None.	

2. That the owners are: (Give names and addresses of individual owners, or, if a corporation, give its name and the names and addresses of the stockholders owning or holding 1 per cent or more of the total amount of stock.)

Kansas Medical Society, Dr. W. S. Lindsay, Topeka, President; Dr. J. F. Hassig, Kansas City, Secretary; Dr. L. F. Barney, Kansas City, Acting Secretary; Dr. L. H. Munn, Topeka, Treasurer.

3. That the known bondholders, mortgagees, and other security holders owning or holding 1 per cent or more of total amount of bonds, mortgages, or other securities are: (If there are none, so state.) None.

4. That the two paragraphs next above, giving the names of the owners, stockholders, and security holders, if any, contain not only the list of stockholders and security holders as they appear upon the books of the company but also, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, is given; also that the said two paragraphs contain statements embracing affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner; and this affiant has no reason to believe that any other person, association, or corporation has any interest direct or indirect in the said stock, bonds, or other securities than as so stated by him.

5. That the average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the six months preceding the date shown above is (This information is required from daily publications only).

W. E. McVey, Editor.

Sworn to and subscribed before me this 26th day of September, 1918.

R. A. Ferlet,
Notary Public.

(Seal)

(My commission expires February 20, 1920.)

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THE JOURNAL
of The
Kansas Medical Society

Vol. XVIII TOPEKA, KANSAS, DECEMBER, 1918 No. 12

The Preparation of Laboratory Specimens and the Interpretation of Laboratory Reports.

WILBUR A. BAKER, M.D.

Assistant Professor of Pathology, University of Kansas School of Medicine, Rosedale; Director of Public Health Laboratory, Rosedale.

Since the campaign of the United States Public Health Department against venereal disease and the opening of the Kansas Public Health Laboratory at Rosedale will place every general practitioner in closer touch with the laboratory, it seems that a few brief concise instructions relative to the preparation and shipment of specimens for laboratory examination might be in order. This article will be confined to the discussion of specimens commonly sent in by the general practitioner. About the greatest bug-bear to the average laboratory is the busy clinician who does not take the time or trouble to properly prepare his laboratory specimens or send adequate data with them. In order for the clinician to secure the most reliable results and the greatest possible assistance from the laboratory it is not only necessary for the pathologist to use the greatest care in his technic, but careful technic must begin with the clinician when he secures the specimen. Another fact which seems rather hard to impress upon the mind of the average clinician is that a specimen must be accompanied by a brief clinical history of the case if the pathologist is to render an intelligent report. This is especially true when bits of tissue are sent in for examination.

BLOOD FOR THE WASSERMANN TEST.

In obtaining blood for the Wassermann test the two most important things to bear in mind are that sufficient blood must be obtained and the blood must not be hemolyzed when it reaches the laboratory. In order to help eliminate this danger of hemolysis the Public Health Department has adopted a mailing outfit containing two vials so that the serum can be separated from the corpuscles before it is mailed to the laboratory. Care should be taken not to moisten or contaminate the vials before use, as a very small amount of water will cause hemolysis. Alcohol or other chemicals should never be used in sterilizing any instruments used in obtaining the blood. The outfit furnished by the Department contains a sterile needle for drawing the blood, but shoud the operator prefer he may use a 10 c.c. Record or Luer syringe and a 21-gauge needle, but these instruments must be sterilized by boiling in normal salt solution (0.85%).

The following points should also be borne in mind: (1) Blood should not be collected within two hours after a meal. (2) The ingestion of alcohol within twenty-four hours previous to taking the blood weakens the reaction and is apt to give rise to a false positive. (3) An anesthetic within twenty-four hours previous to taking the blood is apt to give rise to a false positive.

In adults blood is usually easiest obtained from one of the cubital veins, or if these are too small one of the veins of the leg may be used. In young children it may be obtained with a syringe from one of the external jugulars, or from the anterior fontanelle in infants. Since there may be some who are unfamiliar with the

technic of vena puncture, a brief description of this technic will be given.

A rubber tourniquet or bandage is fastened about the upper arm tightly enough to constrict the veins and make them stand out distally, but not tightly enough to cause disappearance of the radial pulse. The patient is then told to open and close his hand several times, and if this does not make the veins stand out sufficiently, the arm may be hung down and the cubital space slapped briskly with the palm of the hand. The skin over the veins is cleansed with soap, alcohol, and then ether, and the most prominent vein selected. Tincture of iodine may be used for sterilizing the surface, but is open to the objection that it tends to obscure the vein, and many patients will object to its use. Puncture is usually made eaiest just opposite the bend of the elbow. The patient's arm is grasped firmly in the left hand of the operator so that the thumb of the operator rests on the vein at a point about one inch below where the puncture is to be made, exerting pressure and slight traction distally on the vein and thus preventing its slipping away from the needle. The needle is then so directed that it makes an acute angle with the forearm and plunged into the vain. If the needle is entered perpendicularly to the surface of the skin, it is apt to go entirely through the vein, resulting in a hematoma and considerable difficulty in obtaining the desired blood. When the needle has entered the vein the point of it is free, meets no resistance, and the blood soon begins to flow. The blood is allowed to flow into the larger of the two vials until it is nearly full, or if a syringe is used, gentle aspiration is made until at least 8 c.c. of blood is obtained, which is immediately deposited into the large vial. When the desired amount of blood has been obtained the tourniquet is loosened, the needle withdrawn and pressure made over the point of puncture for a few minutes with a pledget of sterile cotton or gauze.

After the blood has been secured, support the vial in an inclined position so that the surface of the blood almost but not quite touches the cork. When coagulation is complete loosen the clot from the walls of the vial by passing a sterile wire or needle around the clot just inside the glass. Allow the vial to stand in a cool place for about twelve hours, or until sufficient clear serum has separated out. At the end of that time pour the clear serum gently into the small voal, leaving the clot and corpuscles in the larger one. Both vials should be corked, labeled and mailed in the double container furnished by the department.

CEREBRO-SPINAL FLUID

If only a Wassermann test is desired on the cerebro-spinal fluid, it may be allowed to flow directly into the larger vial when the lumbar puncture is made. It is then labeled "spinal fluid," marked with the patient's name and sent at once to the laboratory.

If, however, a colloidal gold test is desired, the cerebro-spinal fluid must be free from blood and the vials free from albumen. A special technic is therefore required in preparing the vials. A very satisfactory method is as follows: The vials are washed thoroughly with distilled water, then with 95 per cent alcohol, then rinsed with ether and the ether burned out by holding the vial in a forceps and passing it through a flame until it is thoroughly dried and sterilized. The corks are then replaced and the vials are ready for use. When the lumbar puncture is made the first few c.c. of the spinal fluid is allowed to flow into the larger vial and this labeled Specimen No. 1. This specimen is the one most likely to contain blood and can be used for the Wassermann test, and at least 5 c.c. should be collected in this vial. The smaller vial is reserved for the last two or three c.c. of spinal fluid drawn, as this is less likely to contain blood. It is labeled Specimen No. 2. Both vials are tightly corked, marked with the patient's name and mailed at once to the laboratory.

PUS SMEARS FOR THE GONOCOCCUS.

In acute cases of gonorrhea there is usually little trouble in obtaining suffi-

cient pus for smears or in finding the organism in the smears. In the chronic cases, however, the task becomes infinitely more difficult for both the clinician and the pathologist.

Smears should never be made less than three hours after urination, and in the female the use of douches should be discontinued for at least three days before taking smears. The technic for making smears will be described for male and female paatients.

Male: Cleanse the meatus with soap and rinse well with water. It is important to have the parts clean in order to avoid contaminating the smear with the secretion and many organisms always found around the glans penis. Squeeze the penis so as to milk out the pus from the penile portion of the urethra. When sufficient pus presents at the external orifice of the urethra, collect it on a clean cotton swab and make a smear on a microscopic slide by making a single stroke across the glass with the swab. The smear should be thin, evenly spread, and cover about one-half the surface of the slide, but do not rub the swab back and forth or around and around over the same area, as this destroys or distorts the pus cells so that they do not stain properly and identification of the organisms is difficult or impossible. Allow the smears to dry in the air, label with patient's name, place them film sides together, wrap with paper and mail to the laboratory. Submit at least two smears from each case.

If the case at hand is a chronic one and little or no discharge can be obtained by squeezing the penis, provocative treatment should be tried. For several days before taking the smear have the patient eat the stimulating food previously interdicted and take active exercise. If discharge is entirely absent, pass a mediumly large sound about twenty-four hours before taking the smear. The use of irritating injections such as 0.5 per cent silver nitrate is also of value. When the patient presents himself for examination, massage the prostate and seminal vesicles thoroughly with the patient standing but bent over and the penis pendant. Collect the discharge resulting from the massage and make smears as previously described. Then have him pass his urine into a sterile bottle and send the urine sample and the slides to the laboratory with a statement of the nature of the examination desired.

Female: Wipe off the external genitalia with a piece of dry gauze and with the finger milk out the pus from the urethra and make smears on two slides. Examine the glands of Bartholin and if they show signs of inflammation, express some of the secretion and with a fresh swab make smears from it. Next insert a speculum and with a fresh swab collect some of the secretion from the inside of the cervix and make smears on two slides. Label all slides with patient's name and source of smear. Do not submit vaginal smears, as their examination is not worth while.

SMEARS FOR TREPONEMA PALLIDUM.

Treponema pallidum can often be found microscopically in material from hard chancres or mucous patches if the specimen is properly collected and stained. The treponema pallidum, being an anaerobic organism, will not be found in the superficial secretions, but serum from the deeper part of the lesion must be obtained. This can usually be accomplished by rubbing the lesion briskly with a rough piece of gauze, avoiding bleeding as much as possible. A thin smear is then made from the sanious oozing by collecting some of the serum on the surface of a slide near the end and spreading it with the edge of another slide or with a cotton swab. In some cases it may be necessary to curette the lesion in order to secure sufficient oozing. Allow the smears to dry in air without the application of heat. Submit at least two smears.

BLOOD SMEARS FOR MALARIAL PARASITES, LEUKEMIAS, ETC.

Malarial parasites are more easily found and identified if the blood is collected shortly before a paroxysm is due. The first essential for a good blood smear is a slide that is absolutely clean and free

from any oily substance. This can be accomplished by cleansing the slides with soap and then with acid alcohol. Blood may be obtained from the lobe of the ear or a finger. Cleanse the skin with alcohol and then with ether, rubbing briskly to stimulate the circulation. Puncture with a sterile needle or lancet so that the blood flows freely and does not require compression of the part. Wipe away the first drop of blood, and the drop to be used should be only a little larger than a pin head. Touch the drop of blood with the flat surface of a slide near one end and place the slide in such position that the blood is on the upper surface. Then place the edge of a second slide on the surface of the first at an angle of 30 to 45 degrees and draw it back into the drop of blood so that the blood distributes itself in the acute angle between the two slides. Then move the second slide forward with a sweeping motion and the blood is drawn along by capillary attraction, making a thin film over the first slide. Several smears should be made from each case. Failure to find the organisms does not by any means mean their absence in the patient.

BLOOD FOR WIDAL TEST.

Use same technic as in procuring blood for Wassermann except that one or two c.c. is sufficient for the Widal test.

SPECIMENS OF TISSUE FOR EXAMINATION.

In the taking of diagnostic sections of tissue for examinataion considerable judgment and skill is sometimes required to secure a piece that is representative of the pathological condition present. This is especially true in taking diagnostic sections from tumors. The tissue should be taken from the border of the tumor if possible, for it is here alone that the true nature of the tumor can be determined in all cases. The tissue is placed at once in 4 per cent formaldehyde solution (10 per cent formalin) and by the time it reaches the laboratory it will be fixed sufficiently for frozen sections to be made. A statement of the location of the lesion and a brief description of its appearance, duration, etc., should always accompany the specimen. In the examination of bits of tissue the clinician is justified in asking the pathologist for a diagnosis in most cases, providing he has supplied the proper data and the specimen was properly taken.

RABIES OR HYDROPHOBIA.

Heads of animals to be examined for rabies should be shipped to the laboratory as quickly as possible after the animal has died, and if the weather is warm the head should be packed in ice. Dogs should never be shot through the head, as any bad laceration of the brain may make the search for Negri bodies difficult or impossible. It is always much better to shut the suspected animal up and watch it than to kill it at once, for if it has rabies it is sure to die in a few days and the head can then be sent in for examination. The Negri bodies are sometimes very difficult to find, and if the animal died with the symptoms of rabies it is well to recommend the Pasteur treatment, even though the laboratory findings should be negative. The treatment is harmless and there is too much at stake to take chances.

INTERPRETATION OF LABARATORY FINDINGS.

In the interpretation of laboratory reports the most important thing to be remembered is that the laboratory report is only a help to the clinician in making his diagnosis. It constitutes only one link in the chain of facts. A common mistake of the practitioner is to imagine that it is the pathologist who is diagnosing the case, and to allow the laboratory report to override every other piece of evidence which may have been gathered. It is true that the laboratory evidence very often does decide the question and decide it correctly, but it would be a very serious mistake to think that it dispenses with clinical examinations.

In case the laboratory and clinical findings do not agree, another specimen should be submitted at once to the laboratory and further measures taken to find the reason for disagreement. The clinician should never allow a negative laboratory report to swerve his opinion too strongly. All

negative reports are of rather limited value.

WASSERMANN REPORTS.

In the interpretation of Wassermann reports it should be kept in mind that the Wassermann test is a test of the patient's resistance to the disease. Consequently some cases, in which for some reason the patient has not developed anti-bodies in his blood, may show a negative test although the patient may have the disease. A negative report is therefore not of great value in excluding syphilis, since there is practically no stage of syphilis in which 100 per cent of positive reactions are obtained.

A four plus (frankly positive) or a three plus test is reasonably certain evidence that the patient has syphilis in an active form. Any reaction less than three plus should not be regarded as of any very great diagnostic value unless accompanied by clinical evidence. In a known case of syphilis that has had antisyphilitic treatment the weaker positives should indicate the necessity of further treatment.

The percentage of positives is probably smallest in the early stages (primary) of the disease. The highest percentage of positives on blood is obtained during the secondary stage. In the tertiary stage the percentage of positives again drops, and not infrequently one finds a case showing a very active tertiary lesion and a negative Wassermann. In syphilis of the central nervous system the Wassermann test is often negative on the blood, although the spinal fluid almost always shows a positive test. Many cases of hereditary syphilis, especially of the latent type, give negative Wassermanns.

Specific treatment influences the reaction temporarily, independent of the success of the treatment, mercury and potassium iodid tending to make the reaction temporarily negative, Arsphenamine tending to make mild reactions temporarily stronger. This fact is made use of in the so-called provocative test, which is very useful in cases with lowered resistance that give negative Wassermanns. In this test the patient is given a small dose of Arsphenamine (0.3 gm.) and about seven days later another blood specimen is taken for examination.

CEREBRO-SPINAL FLUID TESTS—CELL COUNT.

Normal cerebro-spinal fluid should not have more than about five cells per cu. mm. In tabes dorsalis and general paresis the count is often increased to 50 or 100 cells. In cerebro-spinal lues the count may go as high as 1,000 per cu. mm.

COLLOIDAL GOLD TEST (LANGE'S).

It is now pretty generally accepted that this test is more diagnostic of general paresis than any other single test. In this disease the change takes place in the first five tubes and this is called the "paretic curve." In cerebro-spinal lues the change is most marked in the third, fourth, fifth and sixth tubes. In various types of meningitis other than Luetic the changes are usually most marked in the sixth to the tenth tubes.

The degree of change in each tube is designated by a numeral, ranging from 0 to 5, 0 meaning no change and 5 the strongest change. Example of reading: 0 1 3 4 5 4 2 1 0 0. Here the greatest change is in the fifth tube and this is a paretic curve.

GLOBULIN TEST.

A positive Butyric Acid test (Noguchi) or Nonne test means an increase in the globulin content and is usually present in syphilis of the central nervous system.

PUS SMEARS FOR THE GONOCOCCUS.

The finding of a "gram negative intracellular diplococcus" is practically certain evidence that the organism is a gonococcus. If the material is from the genitals of the male or female, the chance of such an organism being other than the gonococcus is very slight indeed. The finding of a "gram negative extracellular diplococcus" indicates that the organism is probably a gonococcus, but there is a possibility of its being some other organism, especially if the smear is from a female. A simple "negative" report indicates that no organism was found that resembled the gonococcus. Failure to find the gonococcus by

no means indicates its absence in the patient. In chronic cases of gonorrhea the percentage of negative smears will run very high.

TREPONEMA PALLIDUM.

Finding the treponema in a smear or bit of tissue from a lesion is positive evidence that the lesion is syphilitic and very highly infectious. Failing to find the treponema is practically of no value in excluding syphilis.

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Spanish Influenza at the University of Kansas.

NOBLE P. SHERWOOD

From the Department of Bacteriology, University of Kansas.

It is a rather interesting fact that the epidemic of Spanish influenza began in Lawrence coincidently with the assembling of students at the University of Kansas. The first cases which came under observation of the University Health Department were some six in number at one of the fraternity houses. This was about September 25, 1918.

At the very beginning of things there was considerable uncertainty as to what should constitute a diagnosis of the disease. The State Board of Health and the city health officer requested the co-operation of the Department of Bacteriology. Accordingly nose and throat examinations were made in a series of suspected cases and contacts. The results obtained were similar to those obtained at Fort Riley and other cantonment laboratories; *i. e.*, nothing abnormal as to types of bacteria found.

As we look at it now, there was a lapse of some two weeks from this time during which period only a comparatively few isolated cases appeared. About October 5 several cases of suspected influenza were found among the members of the S. A. T. C. The commanding surgeon asked and received co-operation from the Department of Bacteriology in determining whether these were ordinary colds or true influenza. About the only laboratory findings that seemed to be of value were blood counts, as leucopenias were being quite uniformly reported in Spanish influenza cases. Accordingly, twenty blood counts were run on October 5. These showed leucopenias quite uniformly. The commanding surgean, Dr. J. S. Allen, was quite sure that clinically they presented the aspects of influenza and the blood counts seemed to verify the clinical pictures.

In view of the fact that statistics showed that usually about 40 per cent of the military population came down with Spanish influenza during an epidemic, it was quite apparent that, potentially, there was reason to expect some 700 or 800 cases during the next few weeks. Fortunately one of the barracks was nearly complete and could be used for a hospital. The commanding surgeon immediately asked the Chancellor and Dean of the Medical School for assistance. Volunteers among the senior medical students were called for and within six hours, eight senior medical students and three nurses arrived from the University Medical School at Rosedale and the remainder of the senior class came down the following day. The Chancellor's office also obtained the services of an experienced superintendent of nurses to act as head nurse. Within the next twenty-four hours the city health officer had obtained the services of twelve graduate and undergraduate nurses to assist with the work. As further help seemed necessary, the Dean of the Medical School asked for volunteers and obtained the services of practically every junior, sophomore, and freshman medical student enrolled in the University. In addition, the services of two graduate physicians on the faculty at Lawrence were offered and accepted by Dr. Allen.

A large number of women and men of the University faculty and students of the University offered their services. Some of these acted as nurses and nurses' aids; others took charge of the linen room. The women of the faculty installed a diet kitchen to handle food for the patients, and many students and women of the fac-

ulty served faithfully and efficiently in this work. At the same time the local Red Cross met in one of the University buildings and supplied the demand for masks to be worn by all employes and nurses at the hospital. The administrative officers of the University actively co-operated with the Red Cross in obtaining linen and clothing to meet the emergency. The local physicians and a physician from Leavenworth responded to the call and faithfully assisted with the work at the barracks hospital. Five medical officers from Ft. Riley were dispatched to Lawrence in time to co-operate with those already on the ground.

Mr. Joseph Welker, assistant professor of physiology now in the service, worked with untiring energy in helping to perfect the organization. He ably assisted Dr. S. J. Crumbine in planning for a pneumonia hospital to accommodate twenty patients.

The Department of Bacteriology was privileged to organize a laboratory in the barracks hospital. This was operated on a twenty-four-hour basis and took care of the laboratory work requested by the hospital staff. The entire department, several of its present as well as former students and a member of the Department of Zoology, applied themselves to this work.

In all, some 850 cases of influenza developed. As complications it might be of interest to note that sixty-five cases of pneumonia and eight cases of pneumococcus meningitis occurred. There were in all thirty-two deaths. A tribute should be paid to the senior medical students who volunteered as a class to assist in this work. One of their number, Mr. Hepler, made the supreme sacrifice, and two others came down with Spanish influenza.

In regard to the comparatively low death rate, it might be noted that it was not necessarily due to a lack of virulence of the infectious agent concerned, but it is quite as likely due to the following reasons:

1. Immediately upon the breaking out of the epidemic the men were all issued an abundance of blankets.

2. The barracks hospital was exceptionally well ventilated.

3. A two hundred bed hospital was organized within ninety-six hours and accommodations for 500 men within the week.

4. Physicians and nurses and other assistants were quite amply provided within twenty-four hours after the outbreak of the epidemic.

5. Of equal importance was the establishment of a splendid pneumonia hospital.

6. The quite rigid enforcement of a fairly long period of rest and observation following apparent recovery.

The commanding surgeon has asked me to express his appreciation of the co-operation of the University as a whole, and the Medical School in particular, in assisting the medical corps in handling the epidemic.

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Early History of the Medical School of Kansas.

L. E. SAYRE.

In 1885, by action of the legislature, the School of Pharmacy was created as one of the departments of the University of Kansas. The writer was chosen by the Board of Regents to act as head of the department. Coming from Philadelphia, where he had been as instructor and interested in and having connection with medical education, it was but natural that he should be vitally interested in the creation and development of a school of medicine in connection with the University of Kansas, whose charter anticipated and provided for such a school. Arriving at the University in the fall of 1885 it was found that, in connection with Chemistry, there was taught subjects relating to medical chemistry. There was a small exhibit of medicinal chemicals and crude drugs. Professor Bailey, inspired with the idea that the future had in it possibilities of a medical school worthy of the name, had continued the work of his predecessor, Professor Patrick, in keeping intact the faintest beginning of what might, even

then, be called a premedical, or preparatory, medical course. The writer was asked to give courses in physiological chemistry and materia medica to these preparatory students. After a course had been outlined for these students, it was submitted to the medical schools in the East (Pennsylvania, Jefferson, Rush and others) who, for the two years' work as outlined gave a credit of one year toward a regular medical course. In the course of a few years, it is well known, the time came in medical centers to thoroughly test medical education and check up its "Airy Conceit," as it were. From this test, or investigation, it became evident that better equipment, larger instructional forces and personnel were necessary to meet the demand of the times. Fortunately, at this time there had been elected to the University staff of instruction Dr. S. W. Williston—one who was found to be quite equal to the occasion. Dr. Williston said all the conditions required for medical education must be met or complied with at whatever cost. Dr. Williston at once put in operation a two years' course which should properly connect with the best medical colleges for credit. This was accomplished. Subsequently, on the advice of the medical profession and institutions of the state, a full four years' course was established. Dr. Williston, however, being called to the University of Chicago, was obliged to leave the development of this final stage of what was in early days an ideal conception, the real thing—a medical school of the University of Kansas. Such is a brief recital of many years of work from the early insignificant beginning. Looking back over a period of over a quarter of a century and noting the many obstacles which the school has had to face and overcome, it is surprising what progress the school has made with so many odds against it.

In connection with this history, which would be quite incomplete were it not mentioned, it should be noted that among its warm friends and ardent supporters was Gov. Robinson, who looked upon this initiatory period as very important for the State of Kansas and frequently expressed his desire that the foundation of this preparatory work would lead to what it has finally attained. This particular phase the writer would like to emphasize, *i.e.*, the connection of Dr. Robinson and his expressed wishes concerning the school. Dr. Robinson has mentioned a number of times that it was his desire to aid in the establishment of a medical school when the time should be right for that. Unfortunately, Dr. Robinson passed away some years before the time that the real medical school was announced in connection with the University. In his bequest to the University it was a disappointment to the friends of the medical school that he did not mention in this the desire he had so frequently expressed during his life. Intimate friends, however, felt assured that when the appropriation of this bequest should be made it would go in the direction of what seemed to be his epressed wish during his life.

It was during the administration of Hon. E. T. Hackney, who was president of the State Board of Administration, that I was asked by him to put upon record, as the one member of the faculty who knew Dr. Robinson, statements regarding his expressed wishes.

In response to this request the following letter was addressed to Hon. E. T. Hackney, October 21, 1916:

Hon. E. T. Hackney, President State Board of Administration, Topeka, Kansas.

My Dear Mr. Hackney: Permit me, as a friend of Doctor Robinson, to entreat you, as representing the University of Kansas, to use your influence to see that the wish of Governor Robinson, as expressed to me in the presence of Doctor Snow and Noble Prentiss, is carried out.

When I took the Chair of Pharmacy at the University of Kansas, steps were immediately taken to have the work done in the School of Pharmacy accredited as one year's medical work toward the medical degree in the principal medical schools of the East, namely, the University of Pennsylvania, Jefferson Medical College, Rush Medical College, etc. This credit was granted by these institutions. Thus was established a nucleus of a medical school.

Knowing of this effort, Governor Robinson took an interest in the Department and the Dean and because of this, perhaps, became friendly, and, as a friend, talked freely of his lifelong interest in medicine and his desire that this nucleus should grow into a recognized medical school.

Doctor Robinson's early life was associated in medicine with Doctor Holland of Springfield, Massachusetts. Mr. Paul Brooks of Lawrence has a portrait of Doctor Holland just as it always hung in Doctor Robinson's home.

On several occasions Doctor Robinson talked with me about the proposed medical school and how it might be developed. One of the occasions which indelibly impressed itself upon my mind was at the time of the University's quarter-centennial celebration when Dr. Snow and Noble Prentiss and his wife, who were our guests, were invited with a few others to the Robinson farm for the day. While there, Doctor Robinson talked freely of what he had in mind for the proposed medical school. It was after dinner on the lawn this conversation took place. During his talk he distinctly stated he intended to bequeath a substantial sum for the medical school at the University if the University should see its way clear to make such a school possible. Very respectfully yours,

(Signed) L. E. SAYRE.

That the Medical School is in great need of such help as the Robinson estate would give is a question no one would doubt who is at all acquainted with medical education. The present time is one of the most critical for our state school in that, to retain its high standard (Grade "A") it has hitherto enjoyed. To keep this standard it must advance and increase in facilities, keeping pace with the average demands required by American medicine. One of the essential things to be met at once to this end is the erection of a medical building on the University grounds on Mt. Oread. The setting aside by the legislature of the present "Robinson Estate" for the specific purpose of a medical laboratory building would seem to the writer and other friends of Dr. Robinson not only appropriate but essential.

The Medical School, the Profession, and the Public.

MERVIN T. SUDLER, Ph.D., M.D.
Associate Dean, the School of Medicine, University of Kansas.

The relation of the Medical Department of the State University to the medical profession should be one of mutual co-operation and help—in fact, a relation somewhat similar to that which the Agricultural College has established between itself and the farmers of the state. In this instance the farmer can get special training by attending suitable courses. He can also get literature, advice, and information that will help him solve his problems at home.

The Medical School, in addition to training men to practice their profession and supplying them to the population of the state to replace those who move away, or retire, or who die, has tried to make itself generally useful to the profession; though its facilities have not been sufficient to realize this to the fullest extent. It should do this by giving physicians an opportunity for advanced study in the laboratories and clinics; so that the physicians in general practice, as well as one who is practicing a specialty, may get a chance to keep pace with the advancements in medicine with a minimum of effort and expense. The use of its library, both at Rosedale and at home—by means of sending literature on any subject upon request—has been utilized to a considerable extent. As far as possible, the school should aid in complicated laboratory methods of diagnosis; particularly, in contagious cases where the health of the public is concerned. A full measure of usefulness can be obtained only by mutual co-operation and suggestion on the part of the profession of the state and the school. For several years now there has been a committee appointed by the President of the State Medical Society to visit the school and make suggestions that would tend to increase its usefulness to the profession and the general betterment of the school. So far, no results have come from this effort. However, it is still pos-

sible, as the interest in the school may increase so that the committee may become more active and greater efficiency result.

The duties and relation of the medical profession and medical schools to the public are changing rapidly. The recent epidemic of influenza and shortly before that the raising of armies for the great war, have emphasized the necessity for proper health measures, whether they be preventive or curative. This has been publicly realized by such statesmen as Lloyd George and by the sponsors for the health of our army. The demand of the public has been increasing; and at present, twenty-eight states and two cities conduct medical schools as a part of their system of higher education. In order to accomplish results it is necessary for the state to use various agencies; so that when the University founded the medical school primarily with an idea of educating physicians, the development that would shortly be necessary was hardly realized.

In the development of these medical schools in the various states, the results along other lines have been almost as important as the educational side. In the University of Kansas this has taken several directions. The greatest development has been in the hospital—primarily for presenting illustrative cases to students; but at the same time, taking care of crippled children and other cases that under the old order might be neglected.

In order to provide a working library, gifts and purchases of periodicals and books have constantly been made. These books are now beginning to be varied and plentiful enough to make a working library of considerable efficiency.

It has been necessary also to develop laboratories not only for the care of patients in the hospital and the instruction of students; but these have grown so greatly that they also are being used as a public health measure; particularly in regard to venereal diseases.

Also, in order to properly conduct a hospital, it has been necessary to conduct a training school for nurses. Since the demand for public health nursing has become so great, the next expansion will probably occur in this direction. A lack of funds has prevented the development before this time.

This shows definitely that the medical work of a state university has long since outgrown the restricted purpose of merely educating physicians and occupied a broad position in relation to the medical activities of that state; and that it can take its proper place in relation to the profession and the public only by the interest and help of the profession and the appropriation of sufficient funds by the state legislature to achieve these results. Kansas has lagged behind the more progressive states in this particular. May we not hope that this will soon be remedied and that it will occupy its rightful position of maximum usefulness in the near future?

Medical Education and the Period of Reconstruction.

C. F. NELSON, M.D., Ph.D.

University of Kansas, Lawrence.

The world is at the present moment emerging from the horrors of a gigantic conflict which has been destructive beyond our utmost powers of comprehension. Hundreds of thousands of men, women and children are today wounded, sick, undernourished and wrecked nervously as a direct result of this struggle. The war has been won fundamentally, probably wholly, because of the possibility of unselfish cooperative effort on the part of a score of nations and by a spirit of purpose and single-mindedness on the part of millions of loyal men and women who have given liberally both of their substance and of life itself. The fighting is over for the moment and will, in all probability, not be renewed. But real peace can come only with the happiness which abundant health can bring. And now the period of reconstruction is before us.

The State of Kansas has at this moment a distinct and imperative duty to perform

in educating its share of young physicians to help bring comfort and happiness to the many sufferers in Europe as well as to its own boys at home and abroad. Co-operation has won the war and co-operative effort will make the period of reconstruction happy and genuinely possible.

Our efforts should, however, be commensurate with our needs. A distinct departure in the policy of expenditure for medical education is needed in Kansas at once. Preparations for peace must be as simple as were the preparations for war. In providing funds for educating medical men, who are now so sorely needed both at home and abroad, the increased cost in maintaining a first class medical school must be taken into account or nothing worth while can really be accomplished. With five counties in the state now without one bit of medical aid, Kansas must be generous; with devastated Europe needing medical assistance and calling for men her duty in this regard cannot but be clear.

There can be no possible mistake in inaugurating a liberal policy toward educating men for the profession of medicine. Our country needs highly trained medical men more than ever. The conservation of life and happiness for which this war was fought must be put largely into their hands. If men, capable and well enough informed for this task, are not regularly forthcoming, freedom, liberty and peace lost a great deal of their meaning.

Our Government has inaugurated a splendid and significant movement in its comprehensive program for the rehabilitation of disabled soldiers. This impetus to conserve health surely contains the very essence of peace and the antithesis of war. It must spread and it will do so irresistably until each individual citizen comes under its benign influence. Many of the leaders and workers in such a movement must necessarily be high minded, well trained medical men. Kansas cannot afford to be unprepared or not to furnish her share. She can easily afford to support a really first class medical school.

The Dispensary.

NELSE F. OCKERBLAD, B.S., M.D.,
Chief of Clinic.

The Dispensary Clinic of the Medical School of the University of Kansas is primarily used for "case teaching" supplementary to the purely didactic classroom instruction and is thus an indispensable part of the scheme for the training of medical students. Secondarily, the Dispensary Clinic serves as a social service unit in the treatment of disease and in the betterment physically of those who look to us for relief from suffering. In order to be most effective both in teaching and in social uplift through the cure or relief of disease we must have a certain number of free beds in the hospital. As conditions are now we can only admit such patients to the hospital as can pay ten dollars a week, and it almost invariably happens that the most interesting and valuable cases from a teaching point of view and the most needy from an economic standpoint are without means, and are forced to seek relief elsewhere or silently suffer in their homes without proper medical attention.

If we had available 200 free beds in our hospital the attendance at the dispensary clinic would at once increase greatly. Many persons would thus be cured of their disease or be so improved that they could be returned as useful members of society, able to earn their own living again, who might, on the other hand, without such scientific intelligent treatment, become a burden to the state either directly or indirectly.

Another function of our free dispensary is the scientific and exhaustive study of disease, and to this end we should have available every device, instrument or method known to the profession. The Medical School through its clinic would thus properly become a "source of light" to the profession of this section of the country.

A dispensary clinic today is not complete without a social service department where proper following of cases may take place

to discover whether the persons are in need of free treatment and then to see that such persons take the prescribed treatment. The social and financial status of each patient should be investigated completely so that patients who are well able to pay for treatment are directed to a qualified physician and are not made wards of the state.

We have then four aims:

(1) To instruct medical students.

(2) To benefit the social order by proper medical attention to disease.

(3) To study disease exhaustively.

(4) To be a "source of light" to the profession.

And three crying needs:

(1) A complete supply of instruments and equipment.

(2) Free beds available in our hospital.

(3) A social service department.

We have the personnel to do this work. We have abundant human material at hand for teaching and research purposes, all we need is "tools" to work with, that this institution in all its aspects may become second to none among the medical schools of America.

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The Venereal Clinic.

NELSE F. OCKERBLAD, B.S., M.D.

The venereal or urological clinic was opened May 15, 1918, as an effort to give proper time and attention to the diagnosis and treatment of venereal diseases. A short time after the clinic was established it was designated as one of the venereal clinics for the health area of Kansas City by the United States Public Health Service through the Kansas State Board of Health.

As a matter of record and also to be scientifically correct we plan to confirm every diagnosis of syphilis with the laboratory tests. In primary syphilis we rely on the demonstration of the spirocheta pallida of Shaudin with the dark field stage for our diagnosis. When the spirocheta is found, no further tests are necessary and treatment is at once begun. We strive to intelligently separate chancroids from true chancres and accord to each its proper treatment.

Since we have attached to our department of pathology the very excellent Wassermann laboratory conducted by the State Board of Health for the United States Public Health Service with Dr. Baker in charge we have a ready and reliable means of establishing the diagnosis of syphilis in doubtful cases. As a matter of confirmation both to the serologist and the clinician the blood of all clinically syphilitic patients is tested and findings recorded on the patient's dispensary chart. We are thus able to have on our dispensary records either a positive spirochete search or a positive Wassermann before beginning antisyphilitic treatment.

Beginning November 1, 1918, we have had available for free treatment a supply of arsphenamine assigned to us by the United States Public Health Service through the Kansas State Board of Health. With this supply at hand we are able to give immediate attention to many desperately infectious cases of syphilis, that come to our attention.

We are proceeding to treat active syphilis on the basis laid down by the United States Army Medical Corps, which is briefly this:

Treatment to cover a period of two years during which time Salvarsan (arsphenamine) is given intravenously in courses of six, one week apart, four courses in each year. During each course of arsphenamine mercury is given by injection, nine to ten injections of the insoluble and twenty-five to thirty of the soluble mercury salts. Potassium or sodium iodide is given only when there are lesions to be absorbed.

The gonorrhea cases are treated in the manner approved by the most advanced urologists of our times. Endeavor is made to establish the presence of the gonococcus before beginning treatment, isolating it either from urethral pus or secretions expressed from the seminal vesicles or prostate or from the centrifuged morning urine. Male patients are immediately put

on a routine treatment as soon as the diagnosis is established.

It is difficult to get female gonorrhea patients to continue treatment after the acute symptoms have subsided. We try to impress every patient with the seriousness of his disease not alone to himself but to all those with whom he is immediately or remotely associated.

The problem of familial syphilis has as yet only been touched upon, and by familial syphilis I mean syphilis contracted by the father and given to the wife or mother, or where father, mother and children all have syphilis. We have a large number of such families under our observation now and are finding an ever increasing number of them. To properly study this important problem we need the services of a visiting nurse or social worker with a nurse's training who will be able to coordinate the work of the doctor by acting between the doctor and the patients to see to it that the effort of the dispensary doctor is not wasted because of neglect of treatment or instructions improperly carried out.

In spite of our best efforts we believe that venereal disease is on the increase—at least it is among the civilian population—and in order to properly combat this tendency we must adopt a plan of procedure which should include all of the following very definite activities:

(1) Study the source of infection and eradicate them with the help of the State Board of Health.

(2) Treat the infected persons so as to render them non-infectious.

(3) By a campaign of education seek to establish a wholesome fear coupled with a correct knowledge of venereal infections.

(4) Enforce the laws now on the statute books.

(5) Teach medical students and the medical profession generally that venereal diseases are worthy of our very best efforts and thought and that such patients are not to be treated as outcasts if they cannot pay or "bled to death" if they can pay.

If we can carry out the above program we can feel sure that we are doing our level best to eradicate venereal disease and maintain the high ideals of a state institution.

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The Medical School and the Great War.

ELEANOR MAUDE KIBBEY, A.B.
Secretary-Registrar The School of Medicine, University of Kansas.

The great war has fully demonstrated the value of technical training; not only in the making of dreadnaughts and the perfecting of aeroplanes, but in the less spectacular science of medicine. Its importance was fully recognized by the government in its request that the medical schools continue in operation, stating that they were munition factories and that the students must not be permitted to enlist. They also requested that enough men must be retained on the faculties to make it possible for the schools to continue their work of putting men into the profession to care for the soldiers abroad and at home and to care for the health of those who were behind the army.

The faculty of the School of Medicine of the University of Kansas has responded so freely to the call of the War Department that a gigantic burden has been borne by those remaining. The school has worked under the greatest difficulties of its varied existence, each man doing more than double duty under inglorious circumstances. Even as "clothes do not make the man," the uniform does not make the hero; and much heroic work has been done by the physician in civilian's clothes. The raging of the influenza epidemic emphasized this fact most forcibly; and the wisdom of the government in providing for medical education throughout the war was more than justified. The work of physicians and of nurses and of students of medicine was worthy of their noble calling.

The School of Medicine of the University of Kansas has a high pride in the actual war service rendered by its various war departments. They have all given their services most generously; and in several

cases their lives have been the price. The lists of those in the service—its faculty, some of its former students, its alumni, its alumni by affiliation*, the alumnæ of the Training School for Nurses—though not entirely complete, show the breadth of the scope of the work of the School of Medicine. Those identified with it are justly proud of this record of service for humanity.

It has been the sacred privilege and the mournful glory of the School of Medicine to contribute five gold stars to the service flag of the institution. The first among those brave ones who so simply gave all was Captain William Thomas Fitzsimmons ('12,—the first American officer to die on foreign soil); closely followed by Lieutenant Benjamin W. J. Worrall ('06), and then Lieutenant Carl Culver ('11). In addition to these, the epidemic of influenza took toll from those self-sacrificing ones; and Dr. Claude H. Case ('07) died in the service of his country while administering to the stricken.

To one not in the profession, it was a splendid tribute to the unostentatious bravery of mankind to see the quiet matter-of-course manner in which the nurses and students of medicine responded to the call to care for their suffering comrades in the Students' Army Training Corps of the University. Brought face to face with the many tragedies of the scourge, they did not shirk or shrink; but valiantly volunteered their services and accomplished unbelievable stupendous work for long hours, one or another dropping out, incapacitated by the disease for a time, but returning and courageously continuing the struggle. The result of this strenuous and self-sacrificing effort was that the mortality of the influenza epidemic of the Students' Army Training Corps of the University of Kansas was far lower than that of any other institution recorded — there being only thirty-four deaths out of the nine hundred students affected.

In this disinterested heroism, however, one of the senior medical students, Russell Calvin Hepler ('19), a member of the Medical Enlisted Reserve Corps, whose attitude had been one of the finest courage and whose zeal had been untiring, succumbed to the disease. A complication of meningitis followed, and his tragic death is a memento of the service of the men of the Medical School to their fellow-men and their country.

"He did not die where bursting shell
Shudder and rend the shaking air,
Nor in some small French village where
The Priest, a faithful sentinel,
In his ruined cloisters tolls his bell;
But here in unsung, patient care,
He bent in mercy's deed to share,
And in unselfish duty fell."

—(Private Willard Wattles,
Camp Funston.)

In the act of the legislature establishing the University in 1862 the founding of a Medical School was contemplated, but conditions were such that it was impossible to carry out these plans at this time. Some steps were taken, as opportunity offered, to further the formation of a Medical School, and in 1880 the "Preparatory Medical Course," under the administration of the College, was established. This continued until 1899, when the School of Medicine was definitely organized, and the first two years of medical instruction was offered.

In the fall of 1905, the Kansas City Medical College (founded in 1869), the Medicochirurgical College (founded in 1896), and the College of Physicians and Surgeons (founded in 1893), were merged into the last two years of a four-year medical course under direction of the University of Kansas.

Excerpts by The Prodigal.

An excellent treatment for scalds and burns is a poultice of bicarbonate of soda. It relieves the pain and is aseptic. It should be left on until the wound is healed, unless there is a rise in temperature or an offensive odor developed.

Books and periodicals which have a glazed finished paper for a background are hard on the eyes of the reader. A dead white or neutral tinted paper is restful to the eyes.

While reading, always sit so that the light falls on the print from the left side and from behind. In the English language, which most of us use, we read from left to right. It is less tiresome for the iris to contract suddenly in facing the light and gradually relax in backing away than to gradually contract up to the point

of facing the light or against it and then to relax.

Close application of the eyes in reading should not be continued longer than from twenty to thirty minutes without an intermission of from three to five minutes.

When the hearing becomes dull or slightly impaired, it may be restored or kept from getting worse by pressing the tragus of the affected ear firmly against the external auditory canal with the finger and jiggle back and forth a dozen times or more. The column of air when pressure is made will push the drumhead in and relax when released and massage the drumhead and the joints of the bones in the middle ear and render the joints more supple. This massage should not be done more frequently than once or twice a week, according to the necessity of the case or the effect produced. Resort should be had to this measure and to inflation of the Eustachian tubes and middle ear according to the benefit received. Overtreatment by massage as heretofore recommended, or inflation, will do injury. In the case of beginning impaired hearing, inflation of the Eustachian tubes and middle ear is usually necessary. If a Politzer bag is not in evidence, Valsalva's method of inflation may be used. Valsalva's method consists in taking a full breath, then shut the mouth and hold the nose tightly so no air escapes from either, then try to force the air out through the nose. When the air passes up through the tubes there is a sense of fullness felt in the middle ear and a crackling sound. If but one ear is involved the normal ear should be protected by pressing the tragus of that ear firmly against its auditory canal while inflating the other ear. By so doing a solid column of air is held against the drumhead of the normal ear and protects it.

In a majority of cases dullness of hearing is caused by catarrh in the middle ear. This catarrh is from continuity of tissue. That is to say the pathological trouble has traveled from the posterior naso-pharynx in the mucous membrane of the Eustachian tube into the middle ear. Hence it is better to treat the naso-pharyngeal mucous membrane in addition to the massage of the middle ear. The sooner treatment is begun after this dullness of hearing is recognized, the better. Overtreatment is the great danger in these cases. The Schneiderian and mucous membrane of the nose and pharynx should not be treated, in these cases, to the extent of irritation. After the treatment the patient should have a feeling of relief and comfort; should hear better, and the head should feel clear.

If an unpleasant stuffy feeling is present and the hearing is not improved at the time, quit or change the treatment. Cerumen in excess together with excessive itching in the auditory canal, one or both is a warning to the owner that trouble has begun and, like the beginning of a fire, the time to put it out of business is now. And now is the time for treatment with almost a positive assurance of success. The cerumenous glands and the mucous membrane (or glands) are irritated, causing over-stimulation, but their function has not been destroyed and they can be restored to normal with mild treatment. But if this irritation is continued the over-stimulation in the course of time will destroy the function of the glands and membrane and when once destroyed they cannot be recreated. A permanent pathological condition is the result of the sin of omission.

It should be remembered that over-medication is fatal and that under-medication gives the patient a chance for his life.

When in doubt the patient should have the benefit of the doubt, and—don't.

It is like the late Frederick Douglass said when asked "What shall we do with the negro?" He replied, "Let him alone and give him a chance, but let him alone."

When a whole catalogue of drugs are recommended for a certain disease it is

proof that the remedy for the disease is not known. The treatment is fashioned after the shotgun prescriptions of the near ancients.

The cause of multiple sclerosis is said to be unknown. Hence its early recognition is important that the treatment may be *palliative* and *expectant*.

It is said that diuretics are indicated in cardiac edema but not in nephritic edema. Sudorifics are indicated in nephritic edema.

The body temperature of a febrile person is reduced more easily by an antipyretic than is the body temperature of a normal person.

That the rise of arterial pressure caused by a dose of strychnine is due to its toxic effect. A safe dose of strychnine does not raise the arterial pressure materially, either in man or beast.

Lassitude, headache and malaise experienced in a close atmosphere in a crowded hall are due to heat and humidity rather than to the inspiration of waste products. The effect of heat and moisture on the skin is the determining cause of the discomfort.

Do You Blame Him?

Dr. M—— was called to see a lawyer. When the doctor entered the room the lawyer said, "Doctor, I have been suffering the pangs of hell for the last two hours."

"What!" said the doctor. "So soon?" And now he is mad at M——.

For Better Rural Health.

Much remains to be done in rural districts, according to the annual report of the Secretary of Agriculture, to control such pests as mosquitoes and the hookworm, to eliminate the sources of typhoid fever, and, even more, to give the country districts the advantage of modern hospitals, nursing and specialized medical practice.

Noting that many agencies, some of them private enterprises with large funds, are working for improvement, the report says that the Department of Agriculture, through its home demonstration service, is giving valuable aid, and the public health service is increasingly extending its functions.

To what extent the further projection of effort is a matter for state or local action remains to be determined, says the Secretary, but it seems clear that there should be no cessation of activities until there has been completed in every rural community of the Union an effective sanitary service and, through the provision of adequate machinery, steps taken to control and eliminate the sources of disease and to provide the necessary modern medical and dental facilities, easily accessible to the mass of the people.

A Short-sighted Druggist.

A correspondent writes: "I went to a near-by drug store and asked for twenty-five cents' worth of Liquor Antisepticus Alkalinus. I got one ounce! The druggist charged me fifteen cents an ounce, and ten cents for the container. Next time I fear I shall be forced to get Glycothymoline." To penalize a man who calls for an official product so as to drive him to ask for a "patent medicine" of the same general character is both poor pharmacy and bad business. (Jour. A. M. A., November 23, 1918, p. 1745.)

Digestive Absurdities.

Scientific investigations have demonstrated beyond any doubt the irrationality of the combinations of digestive ferments which go to make up the various brands of aromatic digestive tablets, and all chemists and manufacturing pharmacists are familiar with these facts. The excuse for manufacturing them is that there is a call for them. It is a question whether the physician who ignorantly prescribes aromatic digestive tablets is not more morally culpable than the pharmaceutical house that supplies what such physicians demand. (Jour. A. M. A., November 2, 1918, p. 1489.)

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W. E. McVEY, M.D. - - - - - Editor

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How Can the Medical School Be of More Service to the Profession?

There was a time when all that was expected of a medical school was to prepare men for the practice of medicine. We expect more of it now. We not only expect it to prepare men for practice, and that is a vastly greater task than it was twenty-five years ago, but we expect the medical school to keep them in a state of preparation—or at least to supply the means for doing so.

In connection with most all of the larger medical schools are clinics and post graduate courses that are open to practitioners; and on account of the fact that they are conducted by experienced clinicians and teachers they offer particular advantages for practical instruction.

The faculty of the modern medical school is made up largely of men who are especially trained and adapted to teaching and who devote their whole time to the school work. Such full time men, if they are efficient, are students as well as teachers. To be good teachers they must also be good students, and it is to such men as these that we look for many of the newer developments. They have the time, the inclination and the stimulus to carry out the long and tedious researches which are proving and disproving many of the old theories of medicine.

Large clinics must be available for instruction in the various departments of medical and surgical practice, and the men who serve in these departments have wonderful opportunities for careful observation and classification. From these men we derive much of our knowledge of diagnosis and of therapeutics.

The medical school is not less important as a preparatory school for physicians, but it has become of much greater importance in its relation to the practice of medicine. Just at this time it may be well to consider in what way our own medical school may be made more serviceable to the physicians of Kansas, for we take it that all our state institutions are intended to serve, to as large extent as possible, the various interests of the people. A considerable advance was made in this direction when the hospital was opened to the poor unfortunates of the state, but there are great facilities there that might be used for the benefit of the physicians of Kansas, and through them for the benefit of the people.

For several years a school for health officers has been conducted at Lawrence and Rosedale. While this has no doubt been highly appreciated, it is too narrow in its scope. Any course of three or four weeks, once a year, is entirely inadequate for the needs of the profession. It might be possible without any serious disarrangement of the regular curriculum of the school to give a series of courses or a continuous course, of clinical and post-graduate instruction. A good many of our men now avail themselves of the clinical advantages offered by Chicago, St. Louis, and other cities, but there are a thousand men in the state who do not. Many because they cannot afford it, others because they cannot leave their business for a sufficient time. The clinical instruction that can be had at the Rosedale School would be very attractive to many of these, and especially so if they could select their least busy time for going.

There is plenty of clinical material to be had and there are excellent instructors. Why should they not be utilized by the physicians of Kansas to the benefit of the people of Kansas?

There is yet another way in which the medical school may be of more service to the physicians of Kansas, and at the same time provide a favorable influence in its own progress. A physician here may be immensely learned in some branch of medicine, his opinion may be respected in Chicago, his papers may be carefully read in New York, but unless the people at home know him and know his ability, he will probably starve to death.

When the state employs teachers for the medical school it does not thereby purchase all the products of their brains, but it is fair to presume that they are loyal to the institution they serve and are interested in its progress. We can not blame the members of the faculty if they wish their work to be known by the men in other schools. We cannot blame them if their first desire is that the school with which they are connected should stand well in the estimation of other schools. But if all the reports of the work done by the members of the faculty and all the papers written by them were published in the Journal, the profession of Kansas would more fully appreciate the importance of the school. Through the profession the people would become familiar with its work and a more generous support would be given it.

It is unfortunate but true that the medical profession of Kansas does not sufficiently appreciate the excellence of its school of medicine. Only those who are its graduates or who are in close touch with its faculty really know much about it. The others only realize the high standing and special qualifications of these men when some other school has taken them away. We believe the profession of Kansas would be fully as appreciative of the merits of these men as the officers of other schools if given the opportunity to read their papers and hear them talk. We believe the publication of articles by these men in the Journal would help to give them standing at home. We also believe that if arrangements could be made for a series of district meetings and members of the faculty engaged to lecture on various subjects, the profession would not only be benefited, but would more fully recognize the possibilities of the school, and its members would use their influence and support for its upbuilding.

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Government Control in Medicine.

It is hardly to be expected that after the great disarrangement of all our private and public affairs they will very readily, or ever, resume their ante-bellum status.

Not reluctantly, but gradually and persistently the states have surrendered their long cherished prerogatives to federal administration. With the growth in magnitude of our industries some centralized authority has become an economic necessity. Before the war sentiment in favor of the government control of public utilities seemed to be growing. What effect the government's emergency administration of these utilities will have upon the ultimate solution of these problems is yet to be learned. The people are still under the restraint occasioned by the war, and it is impossible to determine what impression of a future federal administration of these utilities they may have received.

The emergency which required the placing of a large proportion of the most active men in our profession under federal control may have a very important effect upon the future of medicine. In some of the publicity matter recently sent out for the press it is suggested by a member of the Board of Health of North Carolina "that American soldiers having been carefully treated, having been subjected to scientific methods of diagnosis, blood counts, feces and urine analysis, X-rays, etc., etc., after the war, in all probability will refuse to submit to a medical service that is inferior to what the army has given them." And, "that the question of health matters being taken over as a whole

by the state and federal governments, and the practice of medicine even subsidized, may be one of the results that will eventuate."

Any estimate made at this time, by any officer or civilian, as to the sentiment of the soldiers as a whole upon public health administration or the future of medicine, must be premature. When these soldiers are at liberty to speak without restraint we may learn if the larger number approve and appreciate the excellent work of the medical department, or resent the necessary restrictions to their personal liberties.

No one is yet prepared to say if our civilian population has been more strongly impressed by the carefully systematized and thoroughly efficient service of the medical department under the normal health conditions of our cantonments, or by the ouerstrained service and overtaxed facilities of this department during such crises as were occasioned by the epidemic of measles and pneumonia last winter and the recent epidemic of influenza.

Nor can we predict the attitude of the various medical officers now in service toward the question of federal control of our public health regulations and its possible regulation of the practice of medicine, until these men have been released from the service and are free to express themselves.

The medical department of the army has accomplished a herculean task and has done so with great credit to the medical profession, but we believe, and the reports of last winter justify the belief, that had it been given a free hand, been relieved of a great deal of government red tape, been relieved of the interference of superior officers of other departments, the medical department would have been more quickly and more efficiently organized and would have been more flexible and easily adapted to the emergency requirements that were to be anticipated.

No one is prepared to say with conviction that a medical organization independent of government regulations, organized and equipped for the purpose by the great physicians and surgeons in this country, would have been less efficient. Mr. Hughes has recently said in regard to government control of public utilities:

"It is regrettable, but it is true, that governmental enterprise tends constantly to inefficiency. . . . It cannot fail to be observed that even in connection with the war, despite the endeavor and patriotic impulse of countless workers, inefficiency in important fields of activity has been notorious. The notion that the conduct of business by government tends to be efficient is a superstition cherished by those who either know nothing of government or who know nothing of business. The tendency is strongly the other way.

"Along with this is the grave question of putting the direct operation of these great activities unnecessarily under political control. That is the most serious question. The dovetailing of government with business is apt to injure both."

We do not doubt that the federal administration of our public health regulation would be efficient, but only through municipal and state administration of such regulations can such flexibility and discrimination in their enforcement be secured as to safeguard our industrial pursuits without endangering the public health.

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There are 290 medical students from Kansas in the various schools of the country. Of these 241 are in class "A" schools and 49 in class "C" schools. Of this number 137, or a little more than 47 per cent, are in the Kansas University Medical Department.

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Don't worry. When everybody has been tonsillectomized there will still be the spleen, which seems not to have any useful function.

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We don't envy the health officers. To enforce the ordinary health regulation is sometimes rather difficult, but to devise and try to enforce new regulations to control the epidemic of influenza is some job.

The Red Cross in Jerusalem

How American Red Cross physicians engaged in relief work in Jerusalem are accomplishing worth while results in the face of great difficulties, and what they are up against, is shown in a report just received from W. S. Dodd, A.R.C. doctor working in that section.

With two capable English trained nurses and three native helpers, more or less useful, Dr. Dodd, his "hospital" housed under tents, performed 252 operations in seven weeks, besides giving medical examinations, treatment and counsel to hundreds of the destitute inhabitants and refugees.

His report says in part: "The work of the hospital was of the plainest sort—it might be called primitive. About twenty-five tents comprised the hospital proper, with a dispensary tent, and tents for the living quarters of the staff.

"The soil was all the purest sea-sand with thistles and scant grass; going barefoot was the universal custom, and in our own quarters we of the staff used to follow that custom with great pleasure. * * *

"The professional side of the work was of the greatest interest to me and every day was a pleasure. The clinics numbered sixty to a hundred a day. Of course we had all classes of cases in medicine and general surgery, but by far the larger proportion of our patients were eye cases.

"Of the 252 operation that I did in less than seven weeks, 222 were for the eyes. This is the number of persons operated on, most of them having more than one operation, perhaps on all four lids, so that I really operated on 408 eyes.

"There were some cataracts, not more than would be seen in the same number of cases elsewhere, but trachoma and its consequences accounts for almost all of the eye troubles in this land. I set out to treat these cases radically and secured fine results when I could keep the patients long enough for a reasonable after-treatment. But even so, the number of eyes that can be saved from partial and total blindness is large and the economic value of each eye thus saved is enough to make the prosecution of this line of work of the greatest importance for the redemption of the land.

"The accident cases are always interesting. I had the last end of treatment of some cases of bombed hands, of which there had been quite a number in the earlier days. These were largely in children, and were due to their picking up unexploded Turkish bombs that were lying in the fields from the time of the British advance in the Gaza region. Many fingers and even hands were lost from this cause.

"Vermin was the great enemy we had to fight. Fleas were hardly counted as a problem because we could do nothing against them, they were everywhere and inevitable, and so far as we know at present, not being the carriers of any special diseases, did not come within the hostility of a medical conscience.

"Lice and maggots were a daily terror. How many wounds and injuries came to us filled with maggots I cannot tell. A favorite dressing for a wound is a piece of raw meat, a breeding-place for maggots, and they can hardly be blamed for invading the adjoining premises.

"Many a child had to be put under chloroform in order to search out and pull from their hiding places deep in the middle ear a half dozen wriggling maggots whose every motion was causing torture to the innocent victim.

"A woman came to the clinic complaining of headache. A single sore on her face led to questioning, and when she rather unwillingly undid her turban we found an exaggerated case of impetigo, and every separate sore was as if the whole thickness of the scalp down to the bone had been punched out, and every sore was a nest of maggots. I removed sixty at the first seance, and at the first dressing next day the nurse had more to do. The headache was cured without further treatment. And these are not the most loathsome cases that we saw.

"Another great difficulty with which we had to contend was the filthy habits of the people. In spite of providing proper sanitary facilities, we were compelled to have a scavenger go around every morning and clean up the filth from around the tents of the patients. The women were as bad offenders as the men. We made it a rule that anyone known to have violated these simple sanitary regulations must go without their dinner next day, and this was quite effective punishment."

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Typically American.

Every doctor in the United States should be interested in encouraging American manufacture of typically American medical products. Let us, by enthusiastic patronage of all-American manufacturers, so firmly establish the American supremacy in this field that there will never be

the slightest danger of its passing back to Germany.

One typically American invention is the new wax-impregnated open-mesh lace dressing for wounds, burns, bruises, etc., which bids fair to revolutionize the present-day dressing methods.

Careful tests in large industrial hospitals show that by using this lace mesh, 50 to 75 per cent of the gauze, absorbent cotton, and roller bandages, may be saved, as well as hours of time of surgeons and nurses, not to mention the saving of agony to the patient experienced in the removal of the old sticking secretion-stiffened pad of dressings, for this remarkable dressing does not stick.

Just by way of introduction, the Abbott Laboratories, Chicago, Ill., who make this parresined lace-mesh surgical dressing, offer a special outfit containing a box of six envelopes of the lace-mesh, an ounce of Dakin's Dichloramine-T, and four ounces of Chlorcosane—the solvent for Dichloramine-T—prepaid to any point of the United States for only $2.50. They include, without charge, in the shipment, a trial bottle of Chlorazene, Dakin's water-soluble, stable antiseptic, and one of Digipoten, a typically American digitalis preparation, which leaves you no excuse for using the German. Send for a package today. It has the Abbott guarantee of purity and accuracy.

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Ravages of the Influenza Epidemic.

The influenza epidemic has thus far taken a much heavier toll of American life than has the great war. The total loss of life throughout the country is not known, but the Bureau of the Census has been publishing, for forty-six large cities having a combined population estimated at 23,000,000, weekly reports showing the mortality from influenza and pneumonia. These reports, which cover the period from September 8 to November 9, inclusive, show a total of 82,306 deaths from these causes. It is estimated that during a similar period of time the normal number of deaths due to influenza and pneumonia in the same cities would be about 4,000, leaving approximately 78,000 as the number properly chargeable to the epidemic.

The total casualties in the American Expeditionary Forces have recently been unofficially estimated at 100,000. On the basis of the number thus far reported, it may be assumed that the deaths from all causes, including disease and accidents, are probably less than 45 per cent and may not be more than 40 per cent of the total casualties. On this assumption the loss of life in the American Expeditionary Forces to date is about 40,000 or 45,000.

Thus, in forty-six American cities having a combined population of only a little more than one-fifth the total for the country, the mortality resulting from the influenza epidemic during the nine weeks' period ended November 9 was nearly double that in the American Expeditionary Forces from the time the first contingent landed in France until the cessation of hostilities.

For the forty-six cities taken as a group, the epidemic reached its height during the two weeks ended October 26, for which period 40,782 deaths were reported—19,938 for the week ended October 19 and 20,844 for the following week. Since October 26, however, the decline has been pronounced. During the week ended November 2, 14,857 deaths occurred, and during the following week only 7,798. The only city in which the number of deaths reported for the week ended November 9 exceeded the number occurring during the previous week was Spokane, Washington.

In general, the epidemic traversed the country from east to west. In a number of eastern cities—notably Boston, where the greatest mortality occurred during the week ended October 5—the largest numbers of deaths were reported for earlier periods than that which covered the height of the epidemic for the forty-six cities taken as a group. On the other hand, in New Haven, New York, Pittsburgh, and Rochester, the maximum mortality occurred somewhat later than in eastern cities generally. In Baltimore, Buffalo, and Philadelphia, the two weeks' period ended October 26 showed the greatest number of deaths. For the entire nine weeks' period the greatest mortality due to the epidemic, in proportion to population—7.4 per thousand—occurred in Philadelphia; and the next greatest, 6.7 per thousand—was reported for Baltimore.

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The Prophylactic Value of Vaccine in Influenza.

Some of the reports on the value of vaccines in preventing influenza do not appear to be very encouraging. In the Journal of the American Medical Association, December 7, will be found a report by Dr. Barnes

on his experience with Leary's vaccine. We are unable to find anything in his report that could be considered as indicating any particular immunizing value in this serum.

In the literature sent out by Sherman, however, some very positive and striking results are reported. In the Philadelphia Electric Company thirty-five hundred employes were inoculated and of these not one had influenza. The Sherman vaccine has been used by several practitioners in their private practice. From some of these we learn that only a small per cent of those vaccinated have had influenza, and in those cases that did occur the symptoms were very mild. Those who have made therapeutic use of the Sherman vaccine also report good results.

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The Medical Profession After the War.

In April, 1917, our country called on the medical profession for volunteers for medical service. The response was both prompt and generous. Again and again the call came, and each time met similar prompt and generous response. Some 35,000 physicians have responded to these calls and are serving in the army or in the navy. In addition, about 25,000 physicians have given freely of their time and labor to work on Selective Service Boards, thus making possible that efficient, physically fit machine—the National Army.

It is too soon—the world, victorious and vanquished, too unsettled—to say what is coming and what is to be done. It is an hour in which nations are being made, unmade and remade. We hear, we talk, we read of reconstruction. The reconstruction problems are, in the main, twofold: one, the salvaging of mutilated humanity; the other, the reconstruction of devastated cities, towns and villages. The former, the salvaging of the heroic remnants of war-worn men, is the more important. Our reconstruction problem as applied to the physical reconstruction of the disabled soldiers is certain not to be the gigantic task that it would have been had the war continued for a long period of time. There will, of course, be much to do in this regard; but this work is in competent hands and well provided for. Our reconstruction problem as it applies to the returning of more than 30,000 military physicians to civilian life is again not a problem of magnitude. The physician before he went to war was, in most instances, a man of home and family, and in most instances home, family, his professional confreres and the community wait to welcome him with honors.

However, our reconstruction problem as it concerns the relation of the physician to the great social problems that are to arise "after the war," is a problem of magnitude. One's senses are startled by phrases in the modern writings on social and economic subjects. One hears of "equalization of risk and return," of "conscription of wealth," of "health insurance," of "national ownership," of "state medicine," of a "league of nations," "international medical alliances," and similar conceptions. With these, and as a part of these, will be new problems of the relation of physicians to each other and to the public. Physicians will have as much influence as any other class in the weaving of the new social fabric. It is well to realize this and to appreciate the need of closer knitting together of the profession itself—of stronger organization—so that we may face these problems with the strength of many minds united. Thus the medical profession may be able, not only to secure the rights and recognition it merits, but also to have that real influence necessary for the best interests of the public health in the new order of things. The medical profession has served, it serves and it will continue to serve when called on, but in its altruism must not forget that the profession will have to guard its own rights and prerogatives if they are to be guarded at all.—Journal A.M.A., November 16, 1918.

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Value of Vaccination Against Influenza.

There is no conclusive evidence that the Pfeiffer bacillus plays any greater role, if as great, in the present epidemic than any other bacteria found in the respiratory tract in this disease. Also, the influenza bacillus is a very poor antigen. There is, in fact, nothing to show that definite antibodies against this bacillus develop in the course of influenza. Animal experiments show that it requires prolonged immunization before any response becomes apparent. Again, there is no record of controlled experiments on human beings with influenza vaccine. From this it is evident that vaccination against influenza is in a wholly experimental stage. (Jour. A. M. A., November 9, 1918, p. 1583.)

A Commendable Move.

The profession will no doubt be interested in the recent announcement of the Owl Drug Co. stating that beginning December 1 no preparations for the self-treatment of venereal diseases will be sold in the twenty-nine retail stores of the company, located on the Pacific Coast and in the Middle West. When such preparations are called for, the salesman is instructed to explain the new policy of the company and give the customer a carefully prepared confidential circular, which explains the seriousness of all venereal diseases and the importance of consulting a reliable physician and a list of such will be furnished upon request.

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New and Nonofficial Remedies.

Lutein Tablets, H. W. and D, 2 Grains. —Each tablet contains 2 grains of lutein (the fully developed corpora lutea of the hog, dried and powdered). Hynson, Westcott & Dunning, Baltimore, Md. (Journal A. M. A., Nov. 2, 1918, p. 1485.)

Rabies Vaccine (Harris). — An antirabic vaccine standardized by the method of Dr. Harris and stored in vacuo. Each package contains vaccine and apparatus for the administration of one complete treatment. One dose is given daily for ten days or more. National Pathological Laboratories, Chicago. (Jour. A. M. A., November 30, 1918, p. 1825.)

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War Surgery.

J. J. Moorhead (New York), France (Journal A. M. A., August 31, 1918), gives an account of operations performed on 132 patients during the recent spring offensive in the present war. The summary is detailed and his conclusions in substance are as follows: No patient should be operated on until thoroughly warmed unless bleeding is uncontrollable. Patients coming in with a tourniquet, with or without severing of main vessels, are bad risks, as gas gangrene is likely to have developed, and the wound in such cases should never be closed. Any unusual rise of temperature or pulse, especially if associated with restlessness, calls for immediate attention on account of the risk of gas gangrene. Persisting high temperature and pulse almost always mean that the wound is not doing well, unless pneumonia or some other acute systemic condition can be positively shown. Freedom from subsequent infection is directly in proportion to the removal of damaged tissue. Persisting shock

usually indicates hemorrhage. Ether has shown an unusual efficacy when employed to lavage wounds during and after operation, especially when muscle tissue is much involved. Post-operative dressings should be moist for the first few days at least. Drainage will cause infection if used for more than forty-eight hours, especially if rubber tubing is employed in parts subjected to movement, such as the abdomen or chest.

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Tuberculosis Examinations in the Army.

F. B. Trudeau (Saranac Lake, N. Y.), New Haven, Conn. (Journal A. M. A., September 7, 1918), reports his experience in examinations for tuberculosis in training camps at Plattsburg and Camp Devens. He states the lessons that have been taught by experience in this work, namely, the grouping of cases in the history taking as well as in the physical examination itself. He holds that a tuberculosis examining board should occupy only six hours of their time each day in the work, and the number of pulmonary examinations for each medical officer should be at least seventy-five, but should not exceed one hundred. The work is so intensive that it is tiring on both mind and body, therefore, the above time limit is suggested. The routine taking of histories is not of much value, but the one most important procedure in the pulmonary examination is auscultation for rales after cough, performed preferably and if possible at the end of respiration. The disability board to which rejections are referred should consist of three members, the president of the examining board and two others chosen by him from the members of the board. It should have the final disposition of all lung cases referred to it. The average incidence of tuberculosis in the cases examined was 0.5 per cent, slightly lower than in the reserve officers, slightly higher in the National Army, and just this average in the Regular Army.

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